



Pennsylvania

**Retired Employees Health Program
(REHP)**

Benefits Handbook

January 2020



Pennsylvania Employees Benefit Trust Fund (PEBTF)
150 S. 43rd Street, Suite 1
Harrisburg, PA 17111-5700
Phone: 717-561-4750
800-522-7279
www.pebtf.org

To all Eligible Retirees:

The Commonwealth of Pennsylvania provides retirees and eligible dependents with financial protection in the case of illness or injury. The Commonwealth's Office of Administration ("commonwealth") is pleased to offer you these benefits to maintain your health and well-being.

The Retired Employees Health Program (REHP) covers retirees and their eligible dependents who are not eligible for coverage under Federal Medicare Programs. The REHP also provides a Medicare Open Access PPO and a Medicare Part D prescription drug plan to retirees and dependents who are covered by Medicare.

This Handbook is designed to help you understand your health care benefits. Benefits are based on the date of retirement and are different for non-Medicare eligible retirees and Medicare eligible retirees. Please refer to the appropriate section:

- **Health Care Benefits for Non-Medicare eligible retirees**
- **Health Care Benefits for Medicare eligible retirees**

The Handbook is written in plain, everyday language, and attempts have been made to avoid using medical and legal terminology. If you have questions about the terms used in this Handbook, please see the Glossary of Terms or contact the Pennsylvania Employees Benefit Trust Fund (PEBTF) at 1-800-522-7279.

This Handbook has been prepared to help you understand the main features of the medical coverage provided under the REHP. If there are any differences between this Handbook and the benefit contracts (other than differences relating to the commonwealth's right to amend or modify benefits under the REHP), the contracts will control. If any questions arise that are not covered by this Handbook, the benefit contracts will determine how the question will be resolved.

The commonwealth, as sponsor of the REHP, reserves the right at any time to amend or modify any and all benefits under the REHP, including, but not limited to, eligibility requirements, annuitant contribution rates, Least Expensive Plan provisions, and removal or replacement of service providers, in its sole discretion or as required by law, without prior notice or consent of retirees or their dependents. This Handbook (and any other documents you may receive describing the REHP) is not a contract for benefits, is not intended to create any contractual or vested rights in the benefits described and should in no way be considered a grant of any rights, privileges or duties on the part of the commonwealth, its agents or the PEBTF. The PEBTF administers the REHP on behalf of the commonwealth, and is empowered to establish administrative procedures under the REHP. Any such procedures may be applied to all REHP members, or to certain groups or classes of members, as the commonwealth may determine.

If, after reading your Handbook, you still have questions about your benefits or the rules for dependent eligibility, please contact the PEBTF.

To make the most of your benefits under the REHP, there are a few things you need to remember:

Non-Medicare Eligible Retirees

The REHP covers hospital or medical expenses for retirees and their eligible dependents who are **not eligible** for Medicare.

Medicare Eligible Retirees (Reaching Age 65 or disability)

The REHP does **not** cover and does **not** pay for hospital or medical expenses that would ordinarily be covered or paid for by Medicare Part A **or** Medicare Part B for retirees or their dependents who are **eligible** for Medicare, **including eligibility obtained as the result of a disability or a spouse's/domestic partner's employment.**

Although enrollment in Medicare Part B is not mandated by federal law, and there is a monthly premium for Medicare Part B coverage, **the REHP requires Medicare-eligible retirees or dependents to enroll in both Medicare Part A and Part B as a condition of receiving medical and prescription drug coverage under any of the REHP plans. In addition, retirees or dependents who are given the option by Medicare to pay retroactive premiums to enroll retroactively in Medicare Part B must do so in order to retain REHP benefits.**

If you do not enroll in Medicare Part B, there may be a serious gap in your health insurance coverage, leaving you with large medical bills to pay. Because of this, you will want to give serious consideration to retaining coverage in Medicare Part A **and** Part B or to insuring your health care through some other form of insurance. (In rare cases, you or your dependents may have insufficient quarters of Social Security covered earnings to be eligible for Social Security benefits. If you or any of your dependents fall in this category, please contact the PEBTF for instructions.)

If you do not enroll in Medicare Part B you will not be eligible for the Part D prescription drug program offered through the REHP. If you have a coverage gap of 63 or more days when you are not enrolled in a Part D plan or do not have creditable coverage, you may have to pay a late enrollment penalty.

To apply for Medicare coverage or to find out if you are eligible, contact the nearest Social Security Administration Office. When you or a dependent becomes eligible for Medicare or when your Medicare number changes, you must contact the PEBTF as soon as possible.

If your spouse/domestic partner becomes eligible for Social Security benefits because of reaching age 65 or becoming disabled, your spouse/domestic partner should contact the Social Security Administration at 1-800-772-1213 to discuss his or her eligibility for Medicare.

It is your responsibility to contact the State Employees' Retirement System (SERS), or the PEBTF if you do not have a SERS pension, to:

- **Change your address**
- **Add or remove dependents from the REHP**
- **Ask questions about your retirement check**
- **Change coverage (opt out or re-enroll)**

The address and phone number for SERS are as follows:

State Employees' Retirement System Central Office
30 North Third Street, Suite 150
Harrisburg, PA 17101
Field Office Telephone: 1-800-633-5461

Benefit Information

Non-Medicare Eligible Retirees

Non-Medicare eligible retirees who are enrolled in an HMO or PPO should direct their benefits, ID card and claims questions as follows (and in the order presented):

- a. to the HMO or PPO providing their coverage; and
- b. to the PEBTF at the address or telephone number listed at the bottom of page 4.

Medicare Eligible Retirees

1. Medicare eligible retirees who are enrolled in the Medicare Open Access PPO should direct their benefit ID card and claims questions, as follows (and in the order presented):
 - a. to Aetna at 1-888-272-5651;
 - b. to the PEBTF at the address or telephone number listed at the bottom of page 4.
2. Medicare eligible retirees who are enrolled in Medicare Supplemental should direct their questions as follows:
 - a. to the Medicare Carrier for Medicare claims
 - b. for Medicare Supplemental claims, to Aetna at 1-888-272-5651.

Medicare

Government regulations require that you have a choice of medical plans if you continue working beyond age 65. The same options are available to your spouse/domestic partner when he or she reaches age 65, regardless of your age. If you or a dependent becomes covered under Medicare, contact SERS or the PEBTF to let them know the date Medicare begins.

You must notify the PEBTF if you or one of your eligible dependents is receiving Medicare before age 65, for instance because of End Stage Renal Disease (ESRD) or other disability.

Disclaimer of Liability

It is important to keep in mind that the REHP is a plan of coverage for medical benefits, and does not provide medical services nor is it responsible for the performance of medical services by the providers of those services. These providers include physicians and other medical professionals, hospitals, psychiatric and rehabilitation facilities, birthing centers, mental health or substance abuse providers and all other professionals, including pharmacies and the providers of disease management services.

It is the responsibility of you and your physician to determine the best course of medical treatment for you. The REHP Plan option you have chosen may provide full or partial payment for such services, or an exclusion from coverage may apply. The Handbook explains the extent of such coverage, as well as relevant limitations and exclusions. Coverage may be provided under the PPO option or HMO option, Medicare Open Access PPO, Mental Health and Substance Abuse Program or the Prescription Drug Plan. In each case the PEBTF, as administrator of the REHP on behalf of the commonwealth, has contracted with independent claims payors to administer claims for coverage and benefits under these plan options. These claims payors, as well as the physicians and other medical professionals and facilities who actually render medical services, are not employees of the PEBTF, commonwealth, or the REHP. They are all either independent contractors or have no contractual affiliation with the PEBTF, commonwealth, or the REHP.

The PEBTF, commonwealth, and REHP do not assume any legal or financial responsibility for the provision of medical services, including without limitation the making of medical decisions, or negligence in the performance or omission of medical services. The PEBTF, commonwealth, and REHP do not assume any legal or financial responsibility for the maintenance of networks of physicians, pharmacies or other medical providers under any of the plan options that provide benefits based on the use of network providers. These networks are established and maintained by the claims payors which have contracted with the PEBTF with respect to the applicable plan options, and the claims payors are solely responsible for selecting and credentialing the members of those networks. Finally, the PEBTF, commonwealth, and REHP do not assume any legal or financial responsibility for coverage and benefit decisions under the REHP made by the claims payor under each plan option, other than to pay coverage for benefits approved for payment by such claims payor, subject to the final right of appeal to the commonwealth set forth in the claims procedures described in this Handbook.

Please read this Handbook carefully and share it with your family to ensure that you understand your benefits.

To obtain a quick overview of the benefits provided for non-Medicare eligible and Medicare eligible retirees, please refer to the charts at the back of each respective health care benefits section.

**THIS BENEFIT HANDBOOK IS AVAILABLE IN AN ALTERNATIVE FORMAT.
PLEASE CONTACT THE PEBTF TO DISCUSS YOUR NEEDS.**

Pennsylvania Employees Benefit Trust Fund (PEBTF)

150 South 43rd Street, Suite 1

Harrisburg, PA 17111-5700

Telephone: (717) 561-4750; 1-800-522-7279

www.pebtf.org

REHP BENEFITS AT A GLANCE ...

Eligibility Requirements

Enrollment in the REHP requires that former employees have a retiree status as well as compliance with all of the following criteria:

- Was a permanent full-time employee or permanent part-time employee (working 50% or more) for the 12 months preceding separation from commonwealth employment in a PEBTF eligible position; and
- Was employed for three years from his or her most recent date of hire, except if the employee was furloughed and returned during the recall period or the employee was previously eligible for REHP Contribution Rate Coverage other than through a disability or the employee was in a management position and was separated due to a lack of funds or the loss of an appointed position and he or she returned to commonwealth employment within one (1) calendar year from the date of losing his or her most recent employment with the commonwealth; and
- Was either enrolled in the PEBTF, as either the enrollee or the dependent, on his or her last day actively at work or was eligible for enrollment in the PEBTF on his or her last date actively at work; and
- Does not have a PEBTF debt, or is on a payment plan if there is a PEBTF debt; and
- Once a member becomes eligible for Medicare, whether due to: the receipt of Federal Disability benefits; End Stage Renal Disease; or reaching age 65, the member must enroll in Medicare Part A and Part B to be eligible for medical and prescription drug benefits under the REHP. If given the option to enroll retroactively in Medicare, the member must do so in order to be eligible for the REHP, or to remain eligible if already enrolled. Failure to enroll in Medicare retroactively will result in the termination of REHP benefits from the date first eligible for Medicare until the date the member has both Medicare Part A and Part B; and
- Employees who are enrolled in SERS, PSERS or an ARS in an Age 60, 65, or 67 superannuation age group who change to a Age 50 or Age 55 superannuation age group will be required to remain in the new position for one year until qualifying for the REHP at Age 50 or Age 55 superannuation age; and
- Employees who are enrolled in SERS, PSERS or an ARS in an Age 50 or Age 55 superannuation age group who change to an Age 60, Age 65, or Age 67 superannuation age group who have qualified for Contribution Rate Coverage prior to the change do not lose eligibility they earned for Contribution Rate Coverage. Employees who have not qualified for Contribution Rate Coverage prior to the change must now qualify as Age 60, 65, or 67 superannuation age group to which they have changed; and
- REHP coverage will not be available to any active commonwealth employee; including employees receiving retirement/pension payment through PSERS or ARS; and
- All applicable retiree contributions or monthly premiums must be made on time and in accordance with PEBTF billing and collection policies.

Retiree Contributions

Retirement Date on or After 7/1/05 but Before 7/1/07

While some differences may exist, most retiring employees must contribute 1% of their final annual gross salary as an employee toward the cost of REHP coverage.

Households with two commonwealth retirees must both pay the 1% contribution unless one retiree enrolls as a dependent of another retiree. The retiree who has coverage as a dependent of another commonwealth employee or retiree will not have to pay the 1%. Retirees will not have to pay the 1% contribution until they elect coverage under their own contract.

Retirement Date on or After 7/1/07

While some differences may exist, most employees who retired on or after July 1, 2007 through June 30, 2011 must contribute a percentage of either their final annual gross salary or their final average salary as an employee, whichever is less, toward the cost of REHP coverage. For employees who retired on or after July 1, 2011, the retiree contribution will only be based on the employee's final average salary. For the majority of non-Medicare eligible retirees, the contribution rate shall be 3% of their final annual gross salary or their final average salary, whichever applies. For Medicare eligible retirees the contribution rate will be reduced from 3% to 1.5%. However, retirees who currently have a contribution rate of less than 3% will not be eligible for a reduction upon enrolling in Medicare. For employees in unions that have not agreed to this provision, the current collective bargaining agreement language for that union will apply until such time as new agreements are reached.

If, as an active employee, you were hired on or after August 1, 2003, you pay the retiree contribution, as stated above. For non-Medicare retirees the Basic PPO and HMO options are the least expensive plans (LEP) in your county of residence and are offered at no additional costs. Or, you may purchase, through monthly pension deductions, the Choice PPO. Medicare retirees are not subject to the PPO buy up, unless non-Medicare eligible dependents are on the contract. A single rate buy up applies when one household member is enrolled in the non-Medicare Choice PPO. The family rate buy up would apply if two or more household members are enrolled in the non-Medicare Choice PPO plan.

Non-Medicare Eligible Retirees and Dependents

- **Preferred Provider Organization (PPO) Option (also available to out-of-state residents); two PPOs are offered – Choice PPO and Basic PPO**
- **Choice PPO:**
 - \$20 copayment for Primary Care Physician (PCP) in-network office visit
 - \$45 copayment for in-network specialist office visit
 - \$50 copayment for urgent care visit
 - \$200 copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)
 - In-Network annual deductible of \$400 single/\$800 family
 - Out-of-network: \$800 annual deductible/\$1,600 family; 30% coinsurance of the next \$11,900 single/\$23,800 family of eligible expenses after which the plan pays at 100% of eligible expenses

- **Basic PPO:**
 - \$20 copayment for Primary Care Physician (PCP) in-network office visit
 - \$45 copayment for in-network specialist office visit
 - \$50 copayment for urgent care visit
 - \$200 copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)
 - In-Network annual deductible of \$1,500 single/\$3,000 family
 - Out-of-network: \$3,000 annual deductible/\$6,000 family; 30% coinsurance of the next \$11,900 single/\$23,800 family of eligible expenses after which the plan pays at 100% of eligible expenses

- **Health Maintenance Organization (HMO) Option (requires residency in plan coverage area); this plan is a Custom HMO and offers a limited network of providers and facilities. Only emergency care is covered outside of the service area.**
 - \$5 copayment for Primary Care Physician (PCP) office visit
 - \$10 copayment for specialist office visit
 - \$50 copayment for urgent care visit
 - \$150 copayment for Emergency Room (waived if the visit leads to an inpatient admission to the hospital)
 - No annual deductible
 - No out-of-network benefit

- **Mental Health and Substance Abuse Program**
 - \$20 copayment for in-network mental health office visit (PPO)
 - \$5 copayment for in-network mental health office visit (HMO)
 - \$20 copayment for in-network substance abuse office visit (PPO)
 - \$5 copayment for in-network substance abuse office visit (HMO)
 - \$150 copayment for Emergency Room – HMO; \$200 copayment for Emergency Room - PPO (waived if the visit leads to an inpatient admission to the hospital)
 - Inpatient services covered 100% after annual deductible for members enrolled in the PPO; covered 100% under the HMO
 - Out-of-network (Choice PPO Option): \$800 single/\$1,600 family annual deductible; plan pays 70% of eligible expenses; maximum out-of-pocket \$8,150 single/\$16,300 family; pre-authorization penalty of 20% reduction for non-notification
 - Out-of-network (Basic PPO Option): \$3,000 single/\$6,000 family annual deductible; 30% coinsurance of the next \$11,900 single/\$23,800 family of eligible expenses after which the plan pays at 100% of eligible expenses; pre-authorization penalty of 20% reduction for non-notification
 - No out-of-network benefit if enrolled in the HMO

- **REHP Prescription Drug Plan**
 - Three-tier formulary copayment structure

Medicare-Eligible Retirees and Dependents

▪ Medicare Open Access PPO

- Annual deductible equal to Medicare Part B deductible
- \$20 copayment for Primary Care Physician (PCP) office visit and all outpatient therapy visits if you visit a provider who is eligible to receive Medicare and accepts your plan
- \$30 copayment for specialist office visit for a specialist who is eligible to receive Medicare payment and accepts your plan
- \$100 copayment for Emergency Room copayment (waived if the visit leads to an inpatient admission to the hospital)

▪ REHP Prescription Drug Plan

- Three-tier formulary copayment structure
- Part D prescription drug plan

IMPORTANT NOTE: Under all options, benefits are limited to eligible expenses. Eligible expenses are expenses for covered services that do not exceed the plan allowance as determined by the claims payor with respect to the plan option you've selected. Charges for covered services by a network service provider under the non-Medicare HMO and PPO options are always within UCR limits, but charges by out-of-network providers may not be. You are responsible for all charges in excess of the plan allowance, if you receive services from an out-of-network provider.

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HIGHLIGHTS OF YOUR PLAN

(Non-Medicare Eligible & Medicare Eligible Retirees)

Introduction

This section provides an overview of the information contained in this Handbook. The Handbook is designed to make it easy for you to find answers to questions you have about your benefits.

At the end of the Handbook, you will find a Glossary of Terms. This Glossary defines the important terms you will encounter throughout the book.

When Do I Become Eligible?

If you are covered (or eligible to be covered) under the PEBTF's Plan as an active employee and meet the requirements, you are eligible for REHP benefits. Active employees with suspended benefits will not be eligible for REHP benefits until the debt or obligation is resolved and the suspension of benefits is removed. Active employees who owe contributions from leave without pay with benefits must also make all payments to the PEBTF before being eligible for REHP benefits. The PEBTF will send a letter notifying you of any amounts owed. A State Employees' Retirement System (SERS) counselor will tell you if you are eligible at your retirement counseling session. If you are retiring under a different retirement system, e.g. PSERS, or other approved retirement system (ARS), contact your agency's Human Resource Office for information about eligibility and enrolling in the REHP.

If you sign your retirement papers within 90 days of the termination of your employment and if you are eligible for REHP benefits, your health coverage will begin the day after your coverage as a commonwealth employee ends. Otherwise, you may enroll in the REHP at any time. However, the effective date of coverage cannot be more than 60 days prior to the date you file the Retiree Change Form with SERS for non-Medicare coverage. Medicare eligible retirees will be enrolled the 1st of the month on a prospective basis. Your coverage will continue as long as you are considered a retiree by SERS, PSERS, or other approved retirement system, unless you elect to cancel your coverage or fail to pay any applicable retiree contributions. If you elect to opt out of your coverage, it **can be reinstated** one time only unless it was canceled because of re-employment by the commonwealth and subsequent coverage under the Active Employees Health Program as either an employee or a spouse or domestic partner. Coverage will be available to retirees who do not enroll at retirement or who cancel their coverage because they are receiving health coverage as a dependent on their spouse's/domestic partner's coverage with the commonwealth or other employer. Retirees may either elect medical and prescription drug coverage or must opt out of both medical and prescription drug coverage. Members who are enrolled in PACE/PACENET, TRICARE, or Veteran's Affairs Healthcare have an exception to enroll in medical only coverage.

Coverage for your eligible dependents begins when your coverage begins. Upon the death of the retiree, the surviving spouse/domestic partner may apply for REHP coverage on a self-pay basis. Domestic partners will only have coverage available through December 31, 2020. COBRA coverage may be available for other dependents.

What are my Responsibilities?

Identification Cards

The PPO, HMO and the Prescription Drug Plan will issue ID cards for non-Medicare eligible retirees, depending on elected coverage. If a retiree's non-Medicare eligible spouse/domestic partner is covered, two ID cards will be issued. The appropriate ID card must be presented to obtain benefits for services.

Medicare eligible retirees and dependents will be issued the following: A regular Medicare ID card (the red, white and blue ID card issued by the Social Security Administration), a Medicare Open Access PPO ID card and the REHP Prescription Drug Plan ID card. The appropriate ID card must be presented to obtain services. Present your Medicare Open Access PPO ID card to obtain medical services. Do not destroy your regular Medicare ID card. Keep your Medicare ID card in a safe place.

Prescription Drugs

The REHP contracts with a prescription benefit manager to provide prescription drug coverage for eligible retirees and their dependents.

You should use your REHP Prescription Drug Plan ID card to obtain prescription drugs and pay the appropriate copayment. Low-income Medicare eligible retirees and dependents age 65 years old and older who qualify for Pennsylvania's PACE/PACENET Prescription Drug Program may be able to reduce their out-of-pocket expenses if they enroll in PACE/PACENET. Please call 1-800-225-7223 for more information.

Claiming Your Benefits

Non-Medicare Eligible Members

PPO Option: Under the PPO, in-network or out-of-network providers may be selected to provide your care. You may self-refer to a PPO-network specialist without a referral. However, if you select an out-of-network physician, specialist or hospital, there will be claim forms to file and you will be reimbursed at a lesser amount. The PPO must authorize any non-emergency inpatient hospitalizations. Penalties may be applied if you do not obtain prior authorization from your health plan.

HMO Option: Under an HMO, you must select a Primary Care Physician (PCP) who will provide most of your day-to-day treatment. The HMO plan offered by the REHP is a Custom HMO, which has a limited network of providers and facilities. Emergency care only is covered outside of the service area. Some HMOs still require a PCP referral to a specialist. When necessary, the PCP will refer you for treatment by network specialists, for hospitalization, or for surgery. When your care is provided or coordinated by your PCP there will usually be no claim forms, and other than a small copayment, you will have no out-of-pocket expenses. In general, you will have no coverage if you obtain non-emergency treatment from someone other than your PCP without obtaining a referral from your PCP or authorization from the HMO.

Mental Health and Substance Abuse Program (MHSAP): (Applies to non-Medicare eligible retirees only). Under the MHSAP, you must call a toll-free number and speak with a trained counselor who will gather information and refer you to a mental health or substance abuse professional. After an initial appointment, the mental health or substance abuse professional will discuss your situation with the mental health provider's professional staff and an individual treatment plan will be developed.

Prescription Drug Plan: The Prescription Drug Plan is a generic reimbursement plan. You may obtain a brand-name drug but if an FDA-approved generic is available, you will pay a higher copayment and the cost difference between the brand and the generic drug. The Prescription Drug Plan uses a three-tier system, where the prescription benefit manager maintains a list of generic and brand-name drugs called a formulary. Drugs included on the list are called "preferred." Drugs not on the list are called "non-preferred." You may obtain prescriptions at any network retail pharmacy for up to a 30-day supply. The Prescription Drug Plan also offers three ways for obtaining long-term maintenance prescriptions up to a 90-day supply – mail order, or at a Rite Aid, or at a CVS Pharmacy.

Medicare Eligible Members

Medicare Open Access PPO: Under the Medicare Open Access PPO, you may visit any provider as long as they are eligible to receive Medicare payment and accept your plan.

Prescription Drug Plan: The Prescription Drug Plan is a generic reimbursement plan. You may obtain a brand-name drug but if an FDA-approved generic is available, you will pay a higher copayment and the cost difference between the brand and the generic drug. The Prescription Drug Plan uses a three-tier system, where the prescription benefit manager maintains a list of generic and brand-name drugs called a formulary. Drugs included on the list are called "preferred." Drugs not on the list are called "non-preferred." You may obtain prescriptions at any network retail pharmacy for up to a 30-day supply. The Prescription Drug Plan also offers three ways for obtaining long-term maintenance prescriptions up to a 90-day supply – mail order or at a CVS Pharmacy offer the lowest copay option. This is called Maintenance Choice for Medicare. For a slightly higher copay than you pay for the Maintenance Choice for Medicare, you may obtain a 90-day supply at any pharmacy that agrees to be part of the Part D plan network.

ELIGIBILITY

Available Coverage

If you are under age 65, not eligible for Medicare and qualify for the REHP, you and your covered dependents under age 65, who are not eligible for Medicare, are eligible for the PPO or HMO option in addition to the prescription drug plan.

At the time you enroll in the REHP, you may change your coverage to any plan that is available in your geographic area.

If you or your eligible dependent is age 65 or over, but not eligible for Medicare, you will remain covered under one of the Non-Medicare Plan options and the REHP Prescription Drug Plan.

If you or your eligible dependent is age 65 or over and is eligible for Medicare, you and/or your covered spouse/domestic partner age 65 or over are eligible for the Medicare Open Access PPO and the REHP Medicare Part D Prescription Drug Plan.

If you or your eligible dependent is disabled, under age 65, and eligible for Medicare, the disabled individual is eligible for the Medicare Open Access PPO and the REHP Medicare Part D Prescription Drug Plan.

Spouse/Domestic Partner Eligibility: If you were **hired prior to August 1, 2003** and your dependent spouse/domestic partner is eligible for medical or supplemental benefit coverage through their own employer or through retiree benefits (other than the REHP or RPSPP) he/she must take such coverage unless the spouse's/domestic partner's employer charges a contribution or the spouse's employer offers an incentive not to enroll. The spouse/domestic partner may also enroll in the REHP, but the REHP will pay secondary.

Dependent spouse/domestic partners of retirees **hired on or after August 1, 2003** who are eligible for medical or supplemental benefit coverage through their own employer or through retiree benefits (other than the REHP or RPSPP) must take that coverage regardless of any contribution the spouse/domestic partner must pay and regardless of whether the spouse/domestic partner had been offered an incentive to decline such coverage(s).

Note: A domestic partner and the children of a domestic partner may enroll through December 31, 2019. They may remain covered under the REHP through December 31, 2020.

Other Sources of Coverage

Medicare Policy: The REHP does not cover medical expenses which are eligible under the Federal Medicare Program, Parts A and B. Therefore, it is important that you and your eligible dependents find out if you/they are eligible for Medicare, through your own employment, a spouse's/domestic partner's employment, or a disability. If you have questions about eligibility for Medicare Part A or Part B or if you want to apply for Medicare, contact your local Social Security Administration Office.

The commonwealth cannot require you to enroll in Medicare Part B. However, if you or your eligible dependents do not enroll in Medicare Part B you may have a

serious gap in your health insurance coverage, leaving you with large medical bills to pay. You will not have medical or prescription drug coverage through the REHP. In addition, retirees or dependents who are given the option by Medicare to pay retroactive premiums to enroll retroactively in Medicare Part B must do so in order to retain REHP benefits.

Medicare Part A – Hospital Insurance

Persons enrolled in Social Security and age 65 automatically qualify for Medicare Part A. If you are not receiving Social Security and are age 65 you still qualify for Medicare, but you must actively enroll because enrollment is not automatic. You also may be eligible if you are under age 65 and you receive Social Security disability benefits or suffer from permanent kidney failure, also known as End Stage Renal Disease. The Social Security Administration can provide you with additional information.

Medicare Part B – Medical Insurance

If you are eligible for Medicare Part A, you also are eligible for Medicare Part B. If someone is eligible for Medicare Part B, they are automatically enrolled unless they are over 65 and not receiving Social Security benefits, have End Stage Renal Disease or they specifically decline the coverage. **You should not decline Medicare Part B. You must enroll in Medicare Part B and continue your Part B premium if you want to receive medical and prescription drug benefits under the REHP. If given the option by Medicare to pay retroactive premiums to enroll retroactively in Part B, retirees and dependents must do so in order to retain REHP benefits.**

Medicare Part D – Prescription Drug

If you are eligible for Medicare Part A and B, you also are eligible for Medicare Part D. Because you are enrolled in the REHP Medicare Part D Prescription Drug Plan, **you should not enroll in a separate Medicare Part D plan.** If you enroll in another Medicare Part D plan, you will be disenrolled from REHP medical and prescription drug coverage. Low-income Medicare-eligible retirees and dependents age 65 years old and older who qualify for Pennsylvania's PACE/PACENET Prescription Drug Program may be able to reduce their out-of-pocket expenses if they enroll in PACE/PACENET. Please call 1-800-225-7223 for more information.

Dependent Coverage

You must be enrolled in the REHP in order for your dependents to be eligible under the REHP. Your dependents must be enrolled to be covered under the REHP. You are responsible for any claim incurred by ineligible dependents. You can enroll an eligible dependent at any time. However, the effective date cannot be more than 60 days retroactive from the date the form is received by SERS (or the PEBTF for retirees in PSERS, or approved retirement system (ARS)). It is your responsibility to notify SERS when:

- Your dependent no longer qualifies as an eligible dependent as permitted under REHP rules
- You gain a dependent through birth, adoption, or marriage
- You lose a dependent through divorce/termination of domestic partnership, death or ineligibility under the REHP
- Your spouse's/domestic partner's employment ends or your spouse/domestic partner loses coverage under another employer's plan, other than for failure to pay premiums or other cause
- Your dependent loses eligibility for coverage in a Medicare plan, a Medicaid plan or a state children's health insurance program

See the Glossary for a list of all qualifying life events.

You are required to remove a dependent from coverage when your dependent is no longer eligible for REHP coverage, as indicated below.

- Your dependent no longer qualifies as an eligible dependent as permitted under REHP rules
- You lose a dependent through divorce/termination of domestic partnership, death or ineligibility under the REHP

Termination of coverage is effective the date of the qualifying life event so it is important that you notify SERS within 60 days of the qualifying life event or your dependent will not be able to elect COBRA.

In the case of divorce, your ex-spouse and dependent children of your ex-spouse must be removed from REHP benefits effective the date of divorce. Any claims incurred after the date of divorce are your responsibility. The right to COBRA coverage depends on the timely notification of the divorce. In the case of divorce, the Retiree must notify SERS as soon as the divorce is final to complete a Retiree Change Form. Do not wait until you receive the divorce decree to complete the Retiree Change Form. If the divorce is reported to SERS within 30 days of the effective date of the divorce, the Retiree will not be held liable for any benefit utilization by their ex-spouse or the ex-spouse's dependent children during the 30-day grace period.

In most instances, a spouse/domestic partner who is not eligible for REHP coverage as a result of his or her own commonwealth employment, but has REHP coverage through a spouse or domestic partner will become ineligible for REHP coverage on the date the divorce/termination of domestic partnership from the retiree is final unless he or she elects COBRA Continuation Coverage. (See page 93 for more information about COBRA Continuation Coverage, including a description of when a spouse/domestic partner who is separated but not yet divorced/terminated domestic partnership from the retiree might be eligible for such coverage.)

If your Qualifying Life Event is the addition of a new child, the new child is automatically covered for 31 days after birth, adoption or placement for adoption provided the PEBTF is notified. Coverage for the new child will terminate at the end of the 31-day period unless the child is enrolled within 60 days of the birth, adoption or placement of adoption by completing the appropriate form.

After your child is enrolled, you will have six months to provide an original birth certificate (or decree or another proof of adoption or placement for adoption) and Social Security number in order for your new child to continue to be enrolled for coverage under the Plan. If you fail to provide the required documentation before the end of the six month period, the PEBTF will notify you in writing of the expiration of the period for providing the documentation. You will have until the end of the seventh month to provide the documentation. If the Social Security number is not provided by that time, the new child will cease to be covered under the Plan at the end of the seventh month. If you fail to provide a birth certificate or, for adopted children, the final adoption decree or adoption certificate that proves the child who incurs the claims is yours, you will be deemed to have misrepresented that the child is yours, and coverage will be terminated retroactively to the date of birth (or adoption or placement of adoption). You will be responsible for reimbursing the PEBTF for any claims paid for this child.

The REHP covers the following eligible dependents:

- Spouse/domestic partner, including a common-law-spouse. A domestic partner and the children of a domestic partner may be enrolled through December 31, 2019. They may remain covered under the REHP through December 31, 2020. A Pennsylvania common law marriage will not be recognized unless the common law marriage was entered into prior to September 17, 2003 (see page 20).
- Child under age 26, including:
 - Your natural child (original birth certificate required)
 - Legally-adopted child; includes coverage during the probationary period (Court Adoption Decree is required)
 - Step-child for whom you have shown an original marriage certificate and a birth certificate indicating that your spouse/domestic partner is the parent of the child
 - Child who is under age 18 and for whom you are the legal guardian or legal custodian as demonstrated by an appropriate court order
 - Eligible foster child (until age 18 unless child is required to stay in the foster care system due to special needs or continuing education which will require annual court recertification)
 - Child for whom you are required to provide medical benefits by a Qualified Medical Child Support Order or National Medical Support Notice

NOTE: A retiree must reside in the service area to enroll in an HMO. The HMO plan offered by the REHP is a Custom HMO and offers a limited network of providers and facilities. Emergency care only is covered outside of the service area. Seek emergency care and contact the plan. If you have a dependent who resides outside of the HMO's service area, he/she will have emergency care coverage only and would have to return to the service area for all other medical care; therefore you may want to enroll in a PPO.

Coverage for Dependent Children to Age 26: As a retiree, you may cover your child to age 26. Marriage, residency, tax support and student status are not considered in determining eligibility for children under age 26. Coverage for an eligible child ends on the last day of the month in which the child turns 26 unless the child qualifies as a Disabled Dependent.

The necessary documentation must be presented to SERS when adding a new spouse (original marriage certificate or child (original birth certificate, Court Adoption Papers, etc.)). SERS will notify you of the documentation needed. Contact the PEBTF for instructions if you are covered under PSERS, or ARS.

Adult Dependent Coverage

The REHP provides coverage for dependents age 26 to age 30 on a self-paid basis under certain conditions. Your dependent must meet the following criteria:

- Is not married or in a domestic partnership
- Has no dependents
- Is a resident of Pennsylvania or is enrolled as a full-time student at an accredited educational institution of higher education
- Is not eligible for coverage under any other group or individual health insurance
- Is not enrolled in or entitled to benefits under any government health care benefits program (for example, Medicare or Medicaid)

The adult dependent must enroll in the same REHP medical and prescription drug benefits that the retiree has and must pay a monthly premium directly to the PEBTF for coverage to continue. If the retiree is eligible for Medicare, the non-Medicare eligible dependents will remain in the non-Medicare plan selected by the retiree. The dependent does not have the option of enrolling in REHP coverage that the retiree does not have nor dropping REHP coverage in which the retiree is enrolled. Coverage ends if the retiree's coverage ends.

While this option is available, you will have to pay a monthly premium directly to the PEBTF.

You may contact the PEBTF for information on Adult Dependent Coverage and the monthly premium amounts.

Disabled Dependents

Your unmarried/unpartnered disabled dependent of any age may be covered if all of the following requirements are met:

- Is totally and permanently disabled, provided that the dependent became disabled prior to age 26
- Was your or your spouse's/domestic partner's dependent before age 26
- Depends on you or your spouse/domestic partner for more than 50% support
- Is claimed as a dependent on your or your spouse's/domestic partner's federal income tax return (In the event of a divorce, a member's child may be eligible for coverage if the child is claimed as a dependent by the member every other year pursuant to a divorce decree or similar judgement)
- Completes a Disabled Dependent Certification Form (must be completed by retiree member)

NOTE: A disabled dependent child will not automatically be excluded from coverage if he or she lives outside the retiree's home, but the child's living situation and its ramifications will be taken into account in determining whether the child meets the support requirements. For example, a disabled adult child who lives in a group home or other facility and whose care and expenses are subsidized significantly by the government may no longer be deemed to receive more than half of his or her support from a retiree or his or her spouse/domestic partner. Children of a domestic partner may remain covered under the REHP through December 31, 2020.

Important: It is your responsibility to advise the PEBTF of any events that would cause your disabled dependent to no longer be eligible for coverage. If you fail to advise the PEBTF of any such event **within 60 days of the event**, your dependent will not be able to elect COBRA continuation coverage. You will be responsible for any claims incurred while your dependent was not eligible for benefits.

Recertification will occur every two years and will require a recertification form to be completed and returned within 45 days of the mailing. Based on the responses on the recertification form (PEBTF-6RC) the dependent status will be continued or ended.

A Dependent shall be considered "Totally and Permanently Disabled" if he or she is unable to perform any substantial, gainful activity because of physical or mental impairment that has been diagnosed and is expected to last indefinitely or result in death. The determination whether an individual is totally and permanently disabled will be made by the commonwealth (or its delegate) in reliance upon medical opinion and/or other

documentation (e.g. evidence of gainful employment) and shall be made independently without regard to whether the individual may or may not be considered disabled by any other entity or agency, including without limitation, the Social Security Administration. Accordingly, the commonwealth (or its delegate) may require an individual to submit to an examination by a physician of the commonwealth's own choosing, to determine whether the individual is, or continues to be totally and permanently disabled. Failure to cooperate in this regard is grounds for the commonwealth to determine, without more, that the individual is not, or is no longer, totally and permanently disabled.

If a Dependent Certification Form is needed, the PEBTF will advise you.

Last Day of Coverage for Dependent Child

A dependent child becomes ineligible the day he or she:

- Turns 26 (if not disabled) – dependent is terminated from coverage the last day of the month in which the dependent turns 26
- Is determined by the commonwealth to no longer be totally and permanently disabled if age 26 or older
- No longer meets the dependent eligibility requirements of the REHP

Important: You (or your dependent) must advise the PEBTF within 60 days of an event which causes a child to no longer be an eligible dependent. If you or your dependent fails to do so, your dependent will not be able to elect COBRA continuation coverage. You will be responsible for any claims incurred when your dependent was not eligible for benefits.

Domestic Partnerships

A domestic partner is a same or opposite-sex partner of a retiree who, together with the retiree, meets the following criteria:

- The retiree and his or her partner are engaged in an exclusive committed relationship of mutual caring and support and are and have been, for the six-month period immediately preceding the date on which the retiree applies to have the partner qualify as a domestic partner, jointly responsible for their common welfare and living expenses;
- Neither the retiree nor his or her partner is married or legally separated from any individual;
- The retiree and his or her partner are each at least 18 years old and mentally competent to enter into a contract in the Commonwealth of Pennsylvania;
- The retiree and his or her partner are each the sole domestic partner of each other;
- The retiree and his or her partner have lived in the same residence on a continuous basis for at least six months immediately prior to the date on which the retiree applies to have the partner qualify as a domestic partner and they have the intent to reside together permanently;
- The retiree and his or her partner are not related to each other by adoption or blood to a degree that prohibits or would prohibit marriage in the Commonwealth of Pennsylvania;
- The retiree and his or her partner do not maintain the relationship solely for the purpose of obtaining employment-related benefits;

- Neither the retiree nor his or her partner has been a member of another domestic partnership during the six-month period immediately preceding the date on which the retiree applies to have the partner qualify as a domestic partner (unless the prior domestic partnership ended as a result of the death or marriage of the domestic partner); and
- The retiree and, to the extent applicable, his or her partner, complete any application as may be required by the REHP for qualification of the partner as a domestic partner under the plan and meet applicable documentation requirements.

A retiree and his or her partner must meet the above listed requirements for the partner to be treated as a domestic partner, and, therefore, as an eligible dependent, whether or not any jurisdiction recognizes the couple as having a civil union, domestic partnership, or similar relationship.

Dependent Children of the Domestic Partner: Coverage for domestic partner's dependent children is also available.

Tax Implications: Although retirees who cover domestic partners will be charged the same applicable contribution rates, the IRS requires that some of these contributions be taken on a post-tax basis. In addition, retirees must pay federal and FICA taxes on the value the benefits provided to domestic partners (known as imputed income). The value of the benefits may change.

You will receive a W-2 form if you add a domestic partner. There are no additional taxes for retirees who already have family coverage; for example, a retiree with their own child on coverage will incur no additional charges if they add a domestic partner. In addition, the IRS regulation does not apply to retirees who were married in a state or jurisdiction that recognizes same sex marriage.

NOTE: Domestic partners and children of domestic partners may remain covered under the REHP through December 31, 2020. These members will need to obtain other insurance coverage at that time.

Common Law Marriages

If you and your spouse are married as common law, the REHP will permit you to enroll your common law spouse as a dependent, provided you complete a Common Law Marriage Affidavit and provide any additional information requested by the PEBTF to demonstrate the validity of your common law marriage. There are no exceptions to this rule.

Your common law marriage must be recognized as such by the state in which it was contracted. Most states do not recognize common law marriage and while some states still recognize common law marriage, there is no such thing as a common law divorce. If you list an individual as your common law spouse and subsequently remove him or her from coverage, you will not be permitted to subsequently add someone else as your spouse, common law or otherwise, or as your domestic partner without first producing a valid divorce decree from a court of competent jurisdiction certifying your divorce from your prior common law spouse.

The REHP will only recognize a Pennsylvania common law marriage entered into prior to September 17, 2003.

If you entered into a common law marriage prior to September 17, 2003, and would like to obtain coverage for a common law spouse, you will be required to provide proof of such a common law marriage by presenting documents dated prior to September 17, 2003, such as a deed to a house indicating joint ownership, joint bank accounts, a copy of the cover page (indicating filing status) and signature page (if different) of your federal income tax return indicating marital status as of 2002. Figures reflecting income and deductions may be redacted, i.e. blacked out. Additional documentation may be required as well.

No Duplication of Coverage

If your spouse/domestic partner is enrolled in the PEBTF's health program for commonwealth employees or the REHP, there can be no duplication of coverage. You may remain a dependent under your spouse's/domestic partner's plan until your spouse/domestic partner retires. When your spouse/domestic partner retires, you can enroll in the REHP at that time.

If you are both retired commonwealth employees, you may enroll either as a retiree or as a dependent of your spouse/domestic partner, but not as both. Your dependent child may be enrolled under your or your spouse's coverage, but not both. **An employee who enrolls as the dependent of another commonwealth employee or retiree will not have to pay the retiree contribution, if applicable, until they enroll under their own REHP coverage.**

When Coverage Begins

In most cases, you and your dependents coverage begins the day after your PEBTF coverage as an active employee ends; otherwise, it begins on the date you enroll. Employees with suspended benefits will not be eligible for REHP benefits until the debt or obligation is resolved and the suspension of benefits is removed. Employees who owe contributions from leave without pay with benefits must also make all payments to the PEBTF before being eligible for REHP benefits. The PEBTF will send a letter notifying you of any amounts owed.

If you elect to opt out of any part or all of your coverage, it **can be reinstated** one time only unless it was canceled because of re-employment by the commonwealth and subsequent coverage under the Active Employees Health Program as either an employee or spouse. Coverage will be available to retirees who do not enroll at retirement or who cancel their coverage because they are receiving health coverage as a dependent on their spouse's/domestic partner's coverage with the commonwealth or other employer.

NOTE: Retirees who declined coverage prior to June 1, 2007 are not eligible to enroll in the REHP.

If you marry, your spouse will be eligible for coverage as of the date of marriage; however you must complete an enrollment form to add your spouse. The effective date may be the date of the marriage if you complete a form within 60 days of the marriage date. If you delay in adding your spouse, the effective date cannot be more than 60 days retroactive from the date the form is received by SERS (or the PEBTF for retirees in PSERS, or ARS).

Non-Medicare eligible members, the effective date of coverage cannot be more than 60 days prior to the date you file the Retiree Change Form with SERS. Medicare eligible members will be enrolled the 1st of the month on a prospective basis (if retirement or the addition of a Medicare-eligible dependent is prior to the 1st of the month supplemental coverage will be in place until the Medicare Open Access PPO is active on the 1st of the month).

When Dependent Coverage Begins

A new child will be covered under the plan for 31 days following birth, adoption or placement for adoption. Coverage will not continue if the child is not enrolled within 60 days of birth. **You are required to present the necessary documentation to SERS when adding a spouse or dependent child to REHP coverage. PSERS or ARS members must contact the PEBTF.**

Report changes in your marital or family status to SERS, or to the PEBTF for PSERS or ARS members. You can enroll an eligible dependent at any time. However, the effective date cannot be more than 60 days retroactive. Medical expenses incurred for dependents who are not enrolled in the plan will not be paid.

If you or any eligible dependents are an inpatient in a facility on the date your REHP coverage would normally begin, coverage will not begin until the date of discharge or until the hospital stay is extended as the result of another cause.

When Coverage Ends

Coverage continues for you and your eligible dependents as long as you are considered a retiree by SERS, PSERS, or other approved retirement system, you continue to pay any required premiums and as long as you are not an active commonwealth employee. If the PEBTF, on behalf of the REHP, demands repayment of amounts paid in error, and you do not repay the money or otherwise fail to cooperate with the PEBTF in its recoupment of monies owed, you and your dependents will be ineligible for all future benefits until the money is repaid in full or until you make the first payment under a repayment plan agreed to between you and the PEBTF.

Opt Out: REHP members may choose to opt out of REHP coverage if they have other coverage. Members may opt out of REHP coverage one time only with the option to re-enroll at a later date. You have the following options for medical and/or prescription drug coverage offered by the REHP, as follows:

Non-Medicare eligible retirees:

- Members are required to enroll in both medical and prescription drug coverage or to decline both.
- Members who are enrolled in PACE/PACENET, TRICARE or VA health care have an exception to be enrolled in medical only coverage. A copy of the PACE/PACENET, TRICARE or VA ID card must be provided.
- Anyone who retired before January 1, 2013 and enrolled in a non-Medicare plan before January 1, 2013 will be able to remain in medical only or prescription drug only coverage until they become eligible for Medicare. If the member opts out of medical only or prescription drug only REHP coverage, he or she may not enroll in medical only or prescription drug only REHP coverage upon opting back in to the REHP. Once they become eligible for Medicare they must enroll in both medical and prescription drug coverage or decline both.
- A dependent cannot maintain coverage that a retiree opts out of or declines.

Medicare eligible retirees:

- Members are required to enroll in both medical and prescription drug coverage or to decline both.
- Members who are enrolled in PACE/PACENET, TRICARE or VA health care have an exception to be enrolled in medical only coverage. A copy of the PACE/PACENET, TRICARE or VA ID card must be provided.

IMPORTANT: You may not be enrolled in more than one Medicare Advantage Plan. If you enroll in a Medicare Advantage Plan that is not one of the REHP options, your REHP medical and prescription drug coverage will be terminated.

You may not be enrolled in a private Part D Prescription Drug Plan. If you enroll in a private Part D plan, your REHP medical and prescription drug coverage will be terminated.

To “opt out” of REHP coverage: Please notify the State Employees’ Retirement System (SERS). You will be required to complete a Retiree Change Form and attest to SERS that you have other coverage. You must then forward your completed Retiree Change Form to SERS, Central Office, Attn: Health Benefit Coordinator, 30 North Third Street, Suite 150, Harrisburg, PA 17101. PSERS or ARS members must contact the PEBTF.

To re-enroll in REHP coverage: Please notify SERS. You will be required to complete a Retiree Change Form. Non-Medicare eligible retirees: Mail your enrollment form to the PEBTF. Medicare-eligible retirees: You will be enrolled in the Medicare Open Access PPO. Coverage will be effective the 1st of the month on a prospective basis. PSERS or ARS members must contact the PEBTF.

When Dependent Coverage Ends

Dependent coverage will generally end on the date when:

- Your coverage ends
- Your dependent no longer qualifies as an eligible dependent under the rules of the Plan (for example, divorce, termination of domestic partnership, etc.)*
- You voluntarily drop coverage for your dependent as permitted under REHP rules
- You or your dependent is suspended from REHP coverage for fraud and/or abuse and/or intentional misrepresentation of a material fact and/or failure to cooperate with the PEBTF in the exercise of its subrogation rights and/or failure to provide requested information and/or failure to repay debt to the REHP
- The PEBTF determines an individual had been incorrectly enrolled as a dependent (in such event, coverage may be canceled back to the date the individual was incorrectly enrolled)
- Your Medicare-eligible dependent enrolls in an individual Medicare Advantage Plan or Medicare Part D Prescription Drug Plan

See the Glossary for a list of all qualifying life events.

You must notify the PEBTF if your Dependent no longer qualifies for REHP coverage. If the REHP pays benefits for an individual who was covered as your dependent when benefits are incurred after that individual ceases to be eligible for coverage, you will be required to repay the REHP the full amount of such benefits within 60 days of the date that you are notified of the amount due, unless alternative repayment arrangements are made with the PEBTF. Your dependent or ex-spouse may also lose the right to elect COBRA continuation coverage if you do not notify the PEBTF within 60 days of the date the dependent or ex-spouse no longer qualifies for coverage.

*In the case of divorce, the Retiree must notify SERS as soon as the divorce is final to complete a Retiree Change Form. Your ex-spouse's REHP coverage will be terminated on the actual date of divorce. If the divorce is reported to SERS within 30 days of the effective of divorce, the Retiree will not be held liable for any benefit utilization by the ex-spouse during the 30-day grace period. Do not wait until you receive the divorce decree to contact SERS and complete the Retiree Change Form. If you delay notifying SERS, you will be responsible for any claims incurred by your ex-spouse after the date of the divorce until the time the PEBTF was notified.

If your coverage ends, in certain circumstances, you and your eligible dependent(s) may qualify for continued coverage of health benefits. Please refer to the "COBRA Continuation Coverage" section for more details.

NOTE: If you chose to opt out of coverage, your Dependent must also be opted out of coverage.

Dependent Coverage After Retiree's Death

When your family notifies SERS (or the PEBTF for PSERS or ARS members) of your death, the PEBTF will automatically notify your dependents of the following options:

- Your surviving spouse may elect to purchase the REHP Act 183 Surviving Spouse Coverage by enrolling with SERS and paying the appropriate premium. The REHP extends this benefit to domestic partners. The monthly rate for coverage will be determined by the PEBTF according to your surviving spouse's/domestic partner's eligibility for Medicare and the plan selected (PPO, HMO or Medicare Open Access PPO, and it will be deducted from the annuity benefit your surviving spouse/domestic partner receives. If your surviving spouse/domestic partner does not receive an annuity, or if the annuity is insufficient to cover the monthly rate, he or she will be billed a monthly premium by the PEBTF. If your surviving spouse/domestic partner elects to purchase the REHP under this option, then coverage will continue until his/her death or non-payment of premium. If your survivor spouse/domestic partner elects to cancel coverage, it **can be reinstated** one time only.
- If your surviving spouse/domestic partner or other eligible dependents are not eligible for Medicare, they also will be offered COBRA continuation of health coverage in the REHP. If your surviving spouse/domestic partner and/or eligible dependents elect to purchase the REHP under COBRA continuation, coverage will last up to 36 months. Please refer to the section on COBRA Coverage.
- Domestic partners who have Survivor Spouse Coverage may remain covered under the REHP through December 31, 2020.
- If your surviving spouse/domestic partner qualified for REHP coverage under their own contract, then they may elect such coverage and will be responsible for any applicable retiree contribution based on their retirement date.

Coverage ends if you or your eligible dependents fail to make any required contribution.

Changing Coverage

All Retirees

Non-Medicare retirees, eligible survivor spouses/domestic partners and COBRA enrollees may change plan options during the annual Open Enrollment period. The PEBTF will notify

you in advance of the dates of the annual Open Enrollment; you will be provided with enrollment materials. Cost information of each of the plans will be provided to members who pay for their medical coverage. You and your eligible dependents may enroll in any REHP approved plan which offers service in your county of residence. Any change in coverage is effective on the date specified as the beginning of the next plan year.

You may change plan options during the non-Open Enrollment periods under certain circumstances:

- At the time of retirement and/or initial enrollment or re-enrollment in the REHP
- If the Primary Care Physician (PCP) in an HMO plan terminates affiliation with the HMO
- You move outside of your plan's service area or into the service area of a plan not offered in your prior county of residence
- You have complied with the grievance procedure of your plan, but were unable to resolve the problem
- A qualifying life event that causes a minor dependent to lose coverage

See the Glossary for a list of qualifying life events.

If you change plan options during non-Open Enrollment periods, the effective date of coverage cannot be more than 60 days prior to the date you sign your Enrollment/Change Form and submit any necessary accompanying documentation, or, not more than 60 days if the change is due to a qualifying life event. You must contact SERS (or the PEBTF for PSERS or ARS members) to initiate a change in coverage. If you elect to enroll in a PPO mid-year, you will be responsible for the full annual Deductible. The annual Deductible is not prorated for mid-year enrollments.

Medicare Eligible Retirees

Medicare eligible retirees are enrolled in the Medicare Open Access PPO and the Medicare Part D Prescription Drug Plan.

Do not destroy your traditional Medicare ID card (red, white, and blue card). You may use this ID card for other services or discounts in your community. Do not present your Medicare ID card at the doctor's office if you are enrolled in the Medicare Open Access PPO. Present your Medicare Open Access PPO ID card only. You will receive a new prescription drug ID card for the Medicare Part D prescription drug plan. Any non-Medicare dependents will remain with the non-Medicare Part D prescription drug plan.

BENEFITS UNDER ALL NON-MEDICARE HEALTH PLAN OPTIONS

See PPO and HMO Option sections for summary information

Important – Please Read

The REHP offers the following non-Medicare medical plan options: PPO and HMO. You choose the option that best fits your needs. In addition, the REHP offers mental health and substance abuse benefits, as well as a Prescription Drug Plan. In each case, the REHP has contracted with one or more outside professional claims payors to administer benefits under the options.

There are two PPO plans – the Choice PPO and the Basic PPO. Both PPO plans have annual in-network deductibles that apply to the following: Hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), imaging, skilled nursing facility care and home health care.

To understand the benefits available to you, you should read this section, which describes information which applies under all non-Medicare health plan options, as well as the description in this booklet of the particular health benefit option that covers you (or Prescription Drug Plan, as the case may be). In addition, you should read the section “Services Excluded from All Benefit Options” for a description of limitations applicable to all options.

As you read this booklet, please keep the following in mind:

- This booklet is a summary only. In the event of a conflict between the REHP Benefits Handbook and the health plan contract, the contract will control.
- The claims payor with respect to your health benefit option or Prescription Drug Plan has the authority to interpret and construe the Plan, and apply its terms and conditions with respect to your fact situation. In doing so, the claims payor may rely on its medical policies which are consistent with the terms of the Plan.
- No benefits are paid unless a service or supply is medically necessary (see the “Glossary of Terms”). The claims payor is empowered to make this determination, in accordance with its medical policies.
- With respect to certain options, if you use an out-of-network provider, the claims payor pays a percentage of the “Usual, Customary and Reasonable” or “UCR” charge. Certain claims payors do not determine a UCR charge and instead pay a percentage of the plan allowance (see the “Glossary of Terms”). You are responsible for paying the full amount of the charge above the UCR charge or plan allowance. The claims payor is empowered to determine the UCR charge or plan allowance, in accordance with its own procedures and policies consistent with the terms of the Plan.
- The claims payor is also empowered to determine any limitation on benefits under the terms of the contract. These determinations may include, among others, whether a service or supply is experimental or investigative.

Ambulance Services

Ambulance and Advanced Life Support (ALS) services from the home or the scene of an accident or medical emergency to a hospital are fully covered if medically necessary. Ambulance services and EMS care are also covered even when a patient is not transported to the hospital. The medical necessity for this benefit is determined by the claims payor. Ambulance service between hospitals or from a hospital or skilled nursing facility to your home is covered **if medically necessary. Medically necessary ambulance service generally means that the use of other means of transportation could endanger the person's health. Coverage for ambulance service is provided only if a member has utilized a vehicle that is specially designed and equipped and used only for transporting the sick and injured.** Benefits for ambulance service are not available if the claims payor determines that there was no medical need for ambulance transportation.

Ambulance service is not provided for a vehicle which is not specifically designed and equipped and used for transporting the sick and injured. Ambulance service is not covered for the convenience of the member or the facility, and is limited to those emergency and other situations where the use of ambulance service is medically necessary. If non-emergency transport can be safely effected by means of a non-ambulance vehicle (e.g., a van equipped to accommodate a wheelchair or litter), ambulance service will not be considered medically necessary. Air or sea ambulance transportation benefits are payable only if the claims payor determines that the patient's condition, and the distance to the nearest facility able to treat the patient's condition, justify the use of air or sea transport instead of another means of transportation.

Wheelchair van or litter van transportation is not covered.

For PPO option: Failure to precertify out-of-network, non-emergency services may result in a 20% reduction in benefits payable for non-emergency ambulance services. Also, you will be reimbursed at the out-of-network rate for eligible medically necessary, non-emergency ambulance transports if you use an out-of-network provider.

Case Management

Case Management is a standardized medical assessment process that focuses on providing a member with the appropriate types of health care services in a cost-effective manner when the member is experiencing a high cost or specialized episode of care. Typically, this is a catastrophic illness. The member's needs are assessed by a case manager, who then coordinates the overall medical needs of the member. This could involve such things as arranging for services to be provided in the member's home or setting other than the hospital. The review procedures are provided to members at no additional cost.

Centers of Care

Notwithstanding anything in this Plan to the contrary, the REHP may determine that a service, supply or charge that would otherwise be a Covered Expense shall be a Covered Expense only if the service, supply or charge is furnished by a Hospital or other Provider specifically designated by the REHP as a "Center of Care" for such expense. If the REHP makes such a determination, the Plan shall cover the reasonable costs that you incur in connection with such Covered Expense for transportation, food and lodging, subject to such limitations as the REHP may prescribe.

Chiropractic Care/Spinal Manipulations

PPO Option	HMO Option
<ul style="list-style-type: none"> ▪ Six medically necessary visits per year; then a treatment plan must be submitted for additional visits ▪ \$20 copayment for in-network chiropractic care ▪ Out-of-network care is subject to annual deductible and is reimbursed at 70% plan payment ▪ You should choose a network chiropractor for the highest level of benefits ▪ Payments are based on Plan Allowance. You may be billed for amounts in excess of the Plan Allowance if visit an out-of-network chiropractor 	<ul style="list-style-type: none"> ▪ All outpatient therapies have a combined maximum of 60 visits per year – therapies subject to the maximum include chiropractic/spinal manipulation, physical, occupational, speech (due to a medical diagnosis or the diagnosis of Autism Spectrum Disorders and not developmental), cardiac rehabilitation, pulmonary rehabilitation and respiratory ▪ \$5 copayment for network chiropractic care ▪ Each HMO has its own review procedures. The chiropractic benefit does not cover visits or treatment for the maintenance of a condition. Some of the HMOs may only allow two weeks of treatment for an acute condition ▪ Benefits are payable only if you use an in-network chiropractor; some plans may require a referral from your PCP

Determination on Limitations to Benefits

Benefits under the various plan options may be limited in a number of ways:

- Coverage is limited to medically necessary covered services or supplies.
- Coverage is not provided for charges in excess of the UCR (Usual, Customary and Reasonable) charge or the plan allowance, as applicable.
- Coverage is not provided for services or supplies that are experimental or investigative in nature.
- Certain services and supplies are excluded from coverage or are covered subject to limitations, restrictions or pre-conditions (such as pre-authorization or case management procedures). See, for example, Services Excluded From All Benefit Options.

The REHP authorizes the claims payor with respect to each plan option to determine whether a service or supply is medically necessary, exceeds the UCR charge/plan allowance, is experimental or investigative in nature, or is otherwise subject to an exclusion, limitation or pre-condition. Such decisions may be made pursuant to the claims payor's medical policies and procedures, consistent with the terms of the contract. The commonwealth will

generally not overturn on appeal a decision made by the claims payor which is made within its authority to do so under the terms of the contract.

Durable Medical Equipment (DME), Prosthetics, Orthotics, Medical Supplies and Diabetic Supplies

Annual PPO Deductible Does Not Apply to Items Obtained Under the DMEnson Benefit

DMEnson Benefit Management, a licensed third party administrator, provides DME, prosthetics, orthotics and medical supply services to REHP Non-Medicare eligible members. PPO option does not apply under DMEnson.

- DME includes equipment such as wheelchairs, oxygen, hospital beds, walkers, crutches and braces, breast pumps and supplies for post-partum women, etc.
- Prosthetics and Orthotics (P&O) include artificial limbs, braces (such as leg and back braces), breast prostheses and medically necessary shoe inserts for diabetics.
- Medical supplies include urological and ostomy supplies.
- Diabetic supplies include syringes, needles, lancets, test strips, pumps, glucometers, and insulin.
 - Non-Medicare eligible members should obtain diabetic supplies (syringes, needles, lancets, test strips, pumps and glucometers) from a DMEnson network supplier and insulin under the Prescription Drug Plan.

Members have both a network and out-of-network benefit. If you choose a network provider, you are eligible to receive covered benefits at no cost. To find a network provider, contact DMEnson Benefit Management at **1-888-732-6161** or log on to their web site at www.dimension.net. The network is extensive and it includes most major DME/P&O providers.

Preauthorization is required for the rental of any DME item and the purchase of all DME and P&O devices.

If you use an out-of-network provider, you will be responsible for 30 percent of the allowable amount plus the difference between the actual amount billed by the provider and the DMEnson Benefit Management allowed amount.

The plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics, medical supplies and diabetic supplies. These nationally-recognized standards are used by many insurance companies throughout the country. Most providers and medical facilities are familiar with these guidelines.

NOTE: Equipment or supplies dispensed in a physician's office or Emergency Room setting, provided and billed for as part of home health care, skilled nursing facility care or hospice services; or as part of covered dialysis and home dialysis services will continue to be paid by your medical plan, provided it is billed by the provider and not by a DME supplier, and will not be subject to the DMEnson Benefit Management Program. Your provider may dispense the equipment and will bill your medical plan. For example, if you receive a knee brace or crutches at the Emergency Room, it will be billed to your medical plan. If your doctor writes a prescription for a DME item, you should obtain it from a DMEnson network provider in order to get the highest level of benefits.

Emergency Medical Services

The plan covers emergency medical care as a result of an accident or severe illness as follows:

Emergency Accident Care: Hospital services and supplies for the treatment of traumatic bodily injuries resulting from an accident.

Emergency Medical Care: Hospital services and supplies are covered only if the condition meets the following definition of emergency: The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, which would cause the prudent layperson, with an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention could reasonably result in:

- Permanently placing your health in jeopardy
- Causing other serious medical consequences
- Causing serious impairment to bodily functions
- Causing serious and permanent dysfunction of any organ or part.

Emergency care must begin within 72 hours of the onset of the medical emergency.

Examples of an emergency medical condition include, but are not limited to:

- Broken bone
- Chest pain
- Seizures or convulsions
- Severe or unusual bleeding
- Severe burns
- Suspected poisoning
- Trouble breathing
- Vaginal bleeding during pregnancy

The HMO Emergency Room copayment is \$150 and the PPO Emergency Room copayment is \$200, which is waived if the visit leads to an inpatient admission to the hospital. If you are admitted to the hospital as a result of an emergency, contact your health plan within 48 hours. If you are unable to contact the health plan, a relative or friend may do so for you. The phone number appears on your health plan ID card.

Emergency treatment charges that do not meet the above criteria, as determined by the claims payor, are not covered.

There may be instances where you are placed in a hospital room, but it is considered to be "observation care," which is considered outpatient and not an admittance to the hospital.

Observation services are defined as the use of a bed and periodic monitoring by the hospital's nursing or other ancillary staff, which are reasonable and necessary to evaluate an outpatient's medical condition or determine the need for possible inpatient admission.

Therefore, if you are in observation care from an ER visit, you will be required to pay your \$150 ER copayment (HMO) or \$200 ER copayment (PPO).

All follow-up care should be scheduled in a doctor's office.

Rabies Vaccine After An Exposure: The rabies vaccine, including Rabies Immune Globulin (when medically necessary), is covered by the plan after an exposure to an animal bite and not as a preventive immunization. You will be charged the applicable copayment for each visit to the provider or facility. Doctors' offices may not stock the rabies vaccine. Therefore, you may return to the Emergency Room for additional vaccine injections. A \$150 member copayment (HMO)/\$200 member copayment (PPO) will be charged for each return visit to the Emergency Room. If you receive additional vaccine injections at your PCP's office, you will be charged the \$20 copayment under the Choice PPO or Basic PPO and a \$5 copayment under the HMO for the office visit. The vaccine injections are subject to the annual deductible under the Choice PPO and Basic PPO.

Dental Services Related to Accidental Injury: Emergency dental services rendered by a physician or dentist are covered, provided the services are performed within 72 hours of an accidental injury (unless the nature of the injury precludes treatment within 72 hours, in which event treatment must be provided as soon as the member's condition permits). Services are provided as a result of an accidental injury to the jaw, sound natural teeth, mouth or face. Injury as a result of chewing, biting or teeth grinding is not considered an emergency or accidental injury.

Facility Services

Covered inpatient services at a participating network hospital include the following. PPO option: Services are covered 100% after an annual deductible. HMO option: Services are covered 100%. See the summary benefit charts in each medical plan section.

- Unlimited days in a semiprivate room, or in a private room if determined to be medically necessary by the claims payor
- Intensive care
- Coronary care
- Maternity care admissions
- Services of your network physician or specialist
- Anesthesia and the use of operating, recovery and treatment rooms
- Diagnostic services
- Drugs and intravenous injections and solutions, including chemotherapy and radiation therapy (**NOTE:** Drugs dispensed to the patient on discharge from a Hospital are not covered under the medical plan – use your Prescription Drug Plan; see the section on Specialty Medications)
- Oxygen and administration of oxygen
- Therapy services
- Administration of blood and blood plasma (**NOTE:** You pay 20% of the cost for blood products that are not replaced, or any other limit as may be imposed by the claims payor)

The following outpatient services also are covered at a participating network facility. PPO option: Services are covered 100% after an annual deductible. HMO option: Services are covered 100%. See the summary benefit charts in Section 3:

- Emergency care – \$150 copayment (HMO)/\$200 copayment (PPO), which is waived if admitted as an inpatient
- Pre-admission testing
- Surgery (when referred by your PCP for HMO members)
- Anesthesia and the use of operating, recovery and treatment rooms (anesthesia may not be administered by a surgeon or assistant at surgery); however anesthesia and anesthesia supplies rendered in connection with oral surgery will not be excluded from

coverage solely because they are rendered by the oral surgeon or assistant at oral surgery. The medical plans may provide coverage for anesthesia services for dental care rendered to a patient who is seven years of age or younger or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia

- Services of your network physician or specialist
- Diagnostic services (when referred by your PCP or specialist for HMO members)
- Drugs, dressing, splints and casts
- Chemotherapy, radiation and dialysis services
- Physical, respiratory, occupational, speech (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental), cardiac and pulmonary rehabilitation therapies, including spinal manipulation therapies (see charts for the annual maximums)

Medically necessary services also are covered out-of-network (PPO option) but they are subject to an annual deductible and coinsurance. Also, any changes in excess of the plan allowance as determined by the claims payor are non-eligible expenses and are entirely your responsibility.

Home Health Care

PPO Option	HMO Option
<ul style="list-style-type: none"> ▪ Covered 100% in-network after annual deductible ▪ No day limit for in-network care. You must precertify for both in-network and out-of-network home health care services. ▪ Out-of-network: 70% plan payment after deductible. Non-participating providers may balance bill for the difference between plan allowance and actual charge. ▪ Failure to precertify out-of-network services may result in a reduction in benefits payable for home health care services in accordance with the preauthorization policies of the PPO. 	<ul style="list-style-type: none"> ▪ Covered 100% in-network ▪ You may receive 60 medically necessary visits in a 90-day period. The benefit is renewed when 90 days without home health care have elapsed. Benefits may be renewed at the option of the HMO. Benefits also are provided for certain other medical services and supplies when provided along with a primary service

Benefit Limits Under all Plan Options:

Medically necessary home health care benefits will be provided for the following services when provided and billed by a licensed home health care agency:

- Professional services of appropriately licensed and certified individuals

- Physical, occupational, speech and respiratory therapy
- Medical or surgical supplies and equipment
- Certain prescription drugs and medications
- Oxygen and its administration
- Dietitian services
- Hemodialysis
- Laboratory services
- Medical social services consulting
- Antibiotic intravenous drug treatment
- Durable Medical Equipment (DME)
- Well mother/well baby care following release from an inpatient maternity stay (the mother does not have to be essentially homebound)

You must be essentially homebound. Benefits are also provided for certain other medical services and supplies when provided along with a written treatment plan to the claims payor. The claims payor will review from time to time the treatment plan and the continued medical necessity of home health care visits.

The claims payor requires preauthorization for payment for home health care services.

Benefits are only provided for medically necessary home health care covered services that relate to the improvement of a medical condition. Custodial services and services with respect to the maintenance of a condition are not covered.

You **do not** have to be essentially homebound for medically necessary infused medicine therapy billed by a medical supplier, home health care agency or infusion company.

No home health care benefits will be provided for homemaker services, maintenance therapy, food or home delivered meals and home health aide services.

A patient who needs skilled nursing services for more than 8 hours in a 24-hour period would normally be admitted to or remain in a skilled nursing facility or hospital. Custodial care, such as assistance with bathing or eating, and intermediate care is not covered.

Hospice Care

Hospice care offers a coordinated program of home care and inpatient respite care for a terminally ill member and the member's family. The program provides supportive care to meet the special physical, psychological, spiritual, social and economic stresses often experienced during the final stages of an illness. The plan pays 100% of covered services. You may contact your health plan for a list of participating hospices. This benefit is not renewable.

PPO option members: You may use an out-of-network hospice, but you will be responsible for the deductible, coinsurance and any charges in excess of the plan allowance as determined by the claims payor.

Covered Palliative and Supportive Services

- Professional services of an RN or LPN
- Physician fees (if affiliated with the hospice)
- Therapy services (except for dialysis treatment)
- Medical and surgical supplies and Durable Medical Equipment (DME)
- Prescription drugs and medications

- Oxygen and its administration
- Medical social services counseling
- Dietitian services
- Home health aide services
- Family counseling services

Special Exclusions and Limitations

The hospice care program must deliver hospice care in accordance with a treatment plan approved by and periodically reviewed by the health plan.

No hospice benefits will be provided for:

- Medical care rendered by your physician
- Volunteers, including family and friends who do not regularly charge for services
- Pastoral services
- Homemaker services
- Food or home delivered meals
- Hospice inpatient services except for respite care

Respite care is limited to a maximum of ten days of facility care or 240 hours of in-home care throughout the treatment period.

If you or your responsible party elects to institute curative treatment or extraordinary measures to sustain life, you will not be eligible to receive further hospice care benefits.

Human Organ and Tissue Transplant

If a human organ or tissue transplant is provided from a living donor to a human transplant recipient, the facility and professional provider services described previously are covered, subject to the following:

- When both the recipient and the donor are members, each is entitled to the benefits of the plan.
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this plan provided the treatment is directly related to the organ donation. The non-member donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance or health plan coverage, or any government program. Benefits provided to the non-member donor will be charged against the recipient's coverage under this plan.
- When only the donor is a member, the donor is entitled to the benefits of this plan. The benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance or health plan coverage, or any government program available to the recipient. No benefits will be provided to the non-member transplant recipient.
- If any organ or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered as authorized by the claims payor.

PPO option: Services are covered 100% after the annual deductible. HMO option: Services are covered 100%. Coverage under this plan for the non-member donor will not continue indefinitely. Coverage is limited to the transplant and any immediate follow-up care.

Mastectomy and Breast Reconstruction

Mastectomies are covered if medically necessary, including post-surgery inpatient care for the length of stay that the treating physician determines is necessary to meet generally accepted criteria for safe discharge, and cannot be performed on an outpatient basis. PPO option: Services are covered 100% after an annual deductible. HMO option: Services are covered 100%. The REHP will provide coverage for one medically necessary home health care visit within 48 hours after discharge, when the discharge occurs within 48 hours following admission for the mastectomy. Coverage for reconstructive surgery, including surgery to re-establish symmetry between the breasts after the mastectomy, is provided. Prosthetic devices related to mastectomies are covered under the plan. The REHP also covers physical complications at all stages of the mastectomy, including lymphedemas.

Maternity Services

Childbirth services including pre-and post-natal care, are covered. PPO Option: Hospital and newborn care are covered 100% after an annual deductible. HMO option: Services are covered 100%. Maternity services must be coordinated by a network OB/GYN or your PCP (HMO option). The network OB/GYN will obtain proper authorization from the claims payor. The approval will cover maternity services. Federal law allows mothers and infants to remain in the hospital for 48 hours after a normal delivery or 96 hours after a cesarean.

The plan also covers complications of pregnancy and medical costs due to miscarriage.

Abortion services are only covered in the following cases:

- The abortion is necessary to preserve the life or health of the mother, as certified by the mother's physician
- The abortion is performed in the case of pregnancy caused by rape or incest reported within 72 hours to a law enforcement agent. Incest must be reported within 72 hours from the date when the female first learns she is pregnant.

Where the certifying physician will perform the abortion or has a pecuniary or proprietary interest in the abortion there shall be a separate certification from a physician who has no such interest in accordance with the PA Act 1982-138.

Elective abortions are not covered by the plan. Facility services rendered to treat illness or injury resulting from an elective abortion are covered if approved by the plan.

Mental Health and Substance Abuse Rehabilitation Services (Outpatient)

Mental health and substance abuse treatment and services are not covered by your medical plan except as described below. Please see the section on the Mental Health and Substance Abuse Program (MHSAP). **Only the first claim (one visit per calendar year)** for an office visit incurred with a non-mental health and substance abuse professional and coded with a psychiatric diagnosis will be covered by the medical plan.

Medical Detoxification Treatment for Substance Abuse: The medical plan covers detoxification services as an inpatient or outpatient whichever is determined to be medically necessary by your plan. The MHSAP covers ambulatory detoxification in-network only.

Special Medical/Behavioral Health Care Benefits: Both your medical plan and the MHSAP provide outpatient benefits for the diagnosis and medical management of the

following conditions: Attention Deficit Disorder (ADD), Attention Deficit/Hyperactive Disorder (ADHD), Anorexia, Bulimia and Tourette's Syndrome.

Under the medical plan, physicians may diagnose any of these conditions, and prescribe and monitor medications. No counseling benefits are available under the medical plan. For more information, see the section on Mental Health and Substance Abuse Program.

Coverage for Autism Spectrum Disorders: Benefits for Autism Spectrum Disorders will be provided by the REHP medical plans, the Mental Health and Substance Abuse Program and the REHP Prescription Drug Plan. Coverage is provided for dependent children and young adults to age 21 who have a diagnosis of Autism Spectrum Disorders. The coverage is in accordance with Pennsylvania's Autism Insurance Act (Act 62 of 2008 – HR 1150). Autism Spectrum Disorders include: Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Development Disorder (Not Otherwise Specified).

The REHP will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders, which includes:

- Prescription drugs and blood level tests;
- Services of a psychiatrist and/or psychologist (direct or consultation);
- Applied behavioral analysis; and
- Other rehabilitative care and therapies, such as speech and language pathologists, occupational and physical therapists.

Benefits, up to an annual maximum per year, will be provided as follows:

- The dependent is being treated for an Autism Spectrum Disorder;
- Services must be medically necessary and must be identified in a treatment plan;
- Services must be prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner; and
- Services must be provided by an autism service provider or a person, entity or group that works under the direction of an autism service provider.

Coverage will be provided by the medical plans, the Mental Health and Substance Abuse Program and the Prescription Drug Plan. Coverage will not exceed an annual maximum per year under all benefits combined.

Other Covered Medical Services

Your health plan also covers the following services when ordered by a network physician and authorized by your health plan. Services where you do not pay a copayment are subject to an annual deductible under the PPO option.

- Sterilization – PPO and HMO members no copayment for the surgery
- Bariatric surgery (subject to particular restrictions – see Section 7 and the Claims Payor’s medical policy)
- Sex reassignment surgery (subject to the Claims Payor’s medical policy)
- Dental Services – Removal of fully and partially bony-impacted teeth is covered – PPO members have a \$45 specialist copayment and HMO members have a \$10 specialist copayment and must use a health plan network dentist or oral surgeon; HMO members must also receive a referral from their PCP for HMO plans that require a referral
- Podiatric care for treatment of disease or injury – PPO members have a \$45 specialist copayment and HMO members have a \$10 specialist copayment
- Diabetic education and diabetic foot care. Routine diabetic foot care with a diagnosis of diabetes (coverage is not provided to women with gestational diabetes). Coverage is provided up to four times per calendar year. Diabetic supplies covered under the DME carve-out for retirees – see the Durable Medical Equipment section).
- Durable Medical Equipment (rental or purchase) – see the Durable Medical Equipment section
- Coverage for approved clinical trials – coverage for routine patient costs associated with items and services furnished as part of a clinical trial are covered under your plan. These include physician charges, labs, X-rays, professional fees and other routine medical costs. The coverage does not apply for the actual device, equipment or drug that is typically given to the patients free of charge by the company sponsoring the clinical trial.

Preventive Benefits

The REHP provides coverage for the following preventive benefits under all of its medical plans at 100% for in-network preventive care following U.S. Preventive Services Task Force (USPSTF) guidelines. These guidelines are subject to change.

On the following pages, you will see three charts that outline preventive benefits for adults, women, including pregnant women, and children. Present your medical ID card at your network physician’s office and you will not have to pay a copay for preventive care services.

Preventive Health Benefits	Frequency/Comments
Adults	
Abdominal aortic aneurysm screening	One time screening for men ages 65 to 75 years who have ever smoked
Adult routine physical exams and preventive care (age 19 and over)	One per calendar year
Alcohol screening and counseling	One per calendar year; any future treatment must be obtained under the mental health and substance abuse benefit
Blood pressure screening	One per calendar year
Cholesterol screening	One per calendar year
Colorectal cancer screening – for adults 50 years and older	Fecal occult blood testing – annually Sigmoidoscopy – every 5 years Screening colonoscopy – every 10 years
Depression screening	One per calendar year; any future treatment must be obtained under the mental health and substance abuse benefit
Glucose screening	One per calendar year
Healthy Diet Counseling – for adults with known risk factors for cardiovascular disease, in accordance with USPSTF guidelines	Two visits per calendar year (care may be delivered by your PCP or by referral to other specialists such as nutritionists or dietitians)
Hepatitis B virus (HBV) infection screening	In adults at high risk of infection
Hepatitis C virus (HCV) infection screening	In adults at high risk for infection and a one-time screening for adults born between 1945 and 1965
Immunizations <ul style="list-style-type: none"> ▪ Haemophilus influenza type b (Hib) ▪ Hepatitis A ▪ Hepatitis B ▪ Herpes Zoster (shingles) <ul style="list-style-type: none"> Shingrix – age 50 and older Zostavax – age 60 and older ▪ Human Papillomavirus (HPV) – females & males to age 26 ▪ Influenza (flu) ▪ Measles, Mumps, Rubella (MMR) ▪ Meningococcal ▪ Pneumococcal ▪ Tetanus, diphtheria, pertussis (Td/Tdap) ▪ Varicella (chickenpox) ▪ Immunizations that combine two or more component immunizations to the extent the component immunizations are covered under the Plan 	Doses, recommended ages and recommended populations vary. All recommended routine immunizations are covered at no cost to the member. Vaccines are recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP)
Latent tuberculosis infection (LTBI) screening in asymptomatic adults at increased risk (age 18 and older)	One per calendar year
Medical nutritional counseling	Two visits per calendar year with diagnosis of obesity
Sexually transmitted infections (STIs) screening and prevention counseling	Counseling is one per calendar year; screenings are in accordance with USPSTF guidelines
Tobacco use counseling and interventions	Prescription tobacco cessation products are covered under the prescription drug plan

NOTE: These guidelines are subject to change.

Preventive Benefits	Frequency/Comments
Women	
Well Woman visits	Annual, though 2 OB/GYN and 2 physical exams may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs and other risk factors
Breast cancer chemoprevention counseling	For women at higher risk; includes the chemoprevention medications under the Prescription Drug Plan
Breast cancer genetic test counseling (BRCA)	For women at higher risk
Breast cancer mammography screenings	One per calendar year for women age 40 and older (includes coverage for 3-D mammograms)
Cervical cancer screenings	Cytology (pap smear) one per calendar year
Contraception methods counseling	Counseling is included in physical exam
All Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity.	Prescription drugs and OTC products (sponges, spermicides) are covered under the prescription drug plan All contraceptive products require a prescription
Osteoporosis screening – bone mineral density screening	Age 65 years and older
Screening and counseling for interpersonal and domestic violence	Included in physical exam
STIs counseling and screening	Counseling is two per calendar year; screenings are in accordance with USPSTF guidelines
Pregnant Women	
Prenatal care	First visit to determine pregnancy
Anemia screening	Screening in accordance with the USPSTF guidelines
Breastfeeding support, supplies and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. Certain breast pumps and supplies are covered for post-partum women	You must obtain the breast pumps under the Durable Medical Equipment benefit provided by DMension
Gestational diabetes screening	Screening in accordance with the USPSTF guidelines
Hepatitis B screening	Screening in accordance with the USPSTF guidelines
HIV screening	Screening in accordance with the USPSTF guidelines
Prenatal/postpartum depression screening	Screening in accordance with the USPSTF guidelines
Rh Incompatibility screening	Screening in accordance with the USPSTF guidelines
Urinary tract or other infection screening	At 12 to 16 weeks gestation or at first prenatal visit, if later

NOTE: These guidelines are subject to change.

Preventive Benefits	Frequency/Comments
Children	
Well child visits	Unlimited for children under age 3; one per calendar year for ages 3 to 18
Alcohol screening and counseling	For ages 7 to 18; one per calendar year; any future treatment must be obtained under the mental health and substance abuse benefit
Blood pressure screening	Included in well child visits
Cervical cancer screening	For sexually active females
Cholesterol screening	One per calendar year for children ages 2 through 18
Depression screening	One per calendar year; any future treatment must be obtained under the mental health and substance abuse benefit
Developmental/Behavioral screening	One per calendar year
Glucose screening	One per calendar year for children ages 2 through 18
Hearing screening	For all newborns
Height, weight and body mass index measurements	Included in well child visits
Hematocrit or hemoglobin screening	One per calendar year
Immunizations <ul style="list-style-type: none"> ▪ Diphtheria/Tetanus/Pertussis (DTaP), Tetanus/Diphtheria/Pertussis (Tdap) or Tetanus/Diphtheria (Td) ▪ Haemophilus influenza type b (Hib) ▪ Hepatitis A ▪ Hepatitis B ▪ Human Papillomavirus (HPV) – for females and males ages 9 to 21 ▪ Influenza (members age 18 and older may also receive the vaccine under the Prescription Drug Plan – see the Prescription Drug Plan section for more information) ▪ Measles/Mumps/Rubella (MMR) ▪ Meningococcal (MCV4) ▪ Pneumococcal (PCV) ▪ Polio (IVP) ▪ Rotavirus ▪ Varicella (Chickenpox) ▪ Immunizations that combine two or more component immunizations to the extent the component immunizations are covered under the Plan 	<p>Pediatric immunizations are covered for Members and dependents up to age 21 at no cost</p> <p>Vaccines are recommended by the Centers for Disease Control and Prevention (CDC)</p>
Lead screening	Two per calendar year
Medical nutritional counseling	Two per calendar year with diagnosis of obesity
Medical history	Included in well child visits
Sexually transmitted infections (STIs) prevention counseling and screening	One per calendar year; screenings are in accordance with USPSTF guidelines
Tobacco use counseling and interventions	For ages 7 to 18 years
Tuberculin test	
Vision screening	One per calendar year

NOTE: These guidelines are subject to change.

Preventive Care Covered Medications – No Copayment

The following medications are covered at no cost under your prescription drug plan with a prescription from your doctor.

- Aspirin for the prevention of cardiovascular disease – adults age 50 to 59
- Aspirin to help prevent illness and death from preeclampsia in women age 12 and older after 12 weeks of pregnancy who are at high risk for the condition
- Bowel preparation medications for screening colorectal cancer for adults age 50 through 74
- Contraceptives (for females) including emergency contraceptives and over-the-counter contraceptive products (sponges, spermicides)
- Folic acid daily supplement for women only age 55 or younger who are planning to become pregnant or are able to become pregnant
- Medications for risk reduction of primary breast cancer in women age 35 and older
- Oral fluoride for preschool children older than six months to five years of age without fluoride in their water
- Tobacco cessation and nicotine replacement products – prescription drug coverage is for the generic form of Zyban or brand-name Chantix (limited to a maximum of 168-day supply)
- Statins to help prevent serious heart and blood vessel problems (cardiovascular disease) in adults age 40 to 70 who are at risk. This covers generic low to moderate intensity statins only

NOTE: These guidelines are subject to change.

Private Duty Nursing

Outpatient private duty nursing services are covered under the PPO option only under limited conditions when ordered by a physician and deemed medically necessary for the improvement of a medical condition. Private duty nursing is covered 100% after the annual deductible. Private duty nursing that is primarily for the maintenance of a condition or for the convenience of a family member is not covered. The member may receive up to 240 hours a year of medically necessary, private duty nursing care as defined by the plan that can only be provided by a Registered Nurse or Licensed Practical Nurse (respite care and services provided by Home Health Aides are not covered). In no event will benefits be paid for private duty nursing in excess of eight hours in a day (or other 24-hour period as administered by the claims payor in accordance with its medical policies).

A facility's daily charge includes payment for nursing services provided by its staff. Services provided by a nurse who ordinarily resides in the member's home or is a member of the member's immediate family are not covered. Private duty nursing will be case managed.

Provider Services

Medically necessary covered services in a doctor's office include:

- Diagnosis and treatment of injury or illness (includes diagnostic services)
- Periodic health evaluation and routine check-up
- Immunizations (see Preventive Benefits section)
- Allergy diagnosis and treatment (excluding serum which may be covered by the Prescription Drug Plan)
- Gynecological care and services (HMO members may self refer)
- Maternity/obstetrical care (HMO and PPO – no charge for all visits)
- Family planning consultation
- Diagnosis of the need for mental health or substance abuse treatment – first visit only (see Mental Health & Substance Abuse Program section)
- Emergency care in your physician's office
- Routine diabetic foot care with a diagnosis of diabetes (coverage is not provided to women with gestational diabetes). Coverage is provided up to four times per calendar year
- Diabetic educational training when administered by a nutritionist or dietitian. Diabetic educational training is covered at the initial diagnosis of diabetes, when your self-management changes due to significant changes in your symptoms or conditions (self-management must be verified by a physician) or when your physician decides a new medication or therapeutic process is medically necessary
- Enteral formula when administered under the direction of a physician. Oral administration is limited to the treatment of the following metabolic disorders: phenylketonuria, branched chain ketonuria, galactosemia and homocystinuria
- Replacement of cataract lenses for adults and dependent children following surgery is covered only when new cataract lenses are needed because of a prescription change and you have not previously received lenses within the 24-month period of the current prescription change

PPO option: Services are covered 100% after applicable copayment or annual deductible.

HMO option: Services are covered 100% after applicable copayment.

Skilled Nursing Facility (SNF)

PPO Option	HMO Option
<ul style="list-style-type: none"> ▪ Covered 100% in-network after annual deductible ▪ You may receive 240 days at a participating facility. You must precertify for both in-network and out-of-network services. Failure to precertify may result in a reduction of benefits ▪ Benefit renews 12 consecutive months from the first date of admission to a SNF ▪ Out-of-network: 70% plan payment after deductible, up to 240 days. Non-participating providers may balance bill for the difference between plan allowance and actual charge 	<ul style="list-style-type: none"> ▪ Covered 100% in-network ▪ You may receive 180 days per year at a participating facility. ▪ Benefit renews 12 consecutive months from the first date of admission to a SNF

Benefits are provided for skilled nursing facility (SNF) care, when medically necessary, if:

- You were an inpatient of a hospital for a stay of at least three consecutive days (overnight and not including day of discharge), and, in most cases, must have been transferred to the SNF within 30 days of hospital discharge
- Services must be needed for a condition that was treated during the three-day hospital stay or for a condition that you were previously treated for in the hospital
- The physician must certify that you need skilled care and the claims payor agrees that skilled services were medically necessary on a daily basis
- You must require and receive skilled nursing or skilled rehabilitation services, or both, on a daily basis. Skilled nursing and skilled rehabilitation services are those that require the skills of technical or professional personnel such as registered nurses, physical therapists and occupational therapists. In order to be deemed skilled, the services must be so inherently complex that they can be safely and effectively performed only by, or under the supervision of, professional or technical personnel

Examples of Skilled Nursing or Skilled Rehabilitation Services include:

- Development, management and evaluation of a member's care plan
- Observation and assessment of the patient's changing condition
- Enteral feedings that comprise at least 26 percent of daily caloric requirements and provide at least 501 milliliters per day
- Nasopharyngeal and tracheostomy aspiration (suctioning)
- Insertion and sterile irrigation and replacement of suprapubic catheters
- Applications of dressings involving prescription medications and aseptic (sterile) technique

- Treatment of extensive decubitus/pressure ulcers or other widespread skin disorder
- Ongoing assessment of rehabilitation needs and potential
- Therapeutic exercises
- Gait evaluation and training
- Patient education services to teach a patient self maintenance
- Initial phases of regimen involving administration of medical gases, such as oxygen
- Intravenous or intramuscular injection and intravenous feedings

Examples of Non-Skilled Services, which are considered Personal Care, Intermediate or Custodial Care, are not covered by the Plan:

- Administration of routine oral medications, eye drops and ointments
- General maintenance care of colostomy or ileostomy
- Routine services to maintain satisfactory functioning of indwelling bladder catheters
- Changes of dressings for non-infected postoperative or chronic conditions
- Prophylactic or palliative skin care, including bathing and application of creams, or treatment of minor skin problems
- Routine care of the incontinent patient. The mere presence of a urethral catheter does not justify a need for skilled care
- Rehabilitation services provided less than five days per week
- General maintenance care in connection with plaster casts, braces or similar devices
- Use of heat as palliative or comfort measure
- Routine administration of medical gases, such as oxygen, after a regimen of therapy has been established
- Assistance with activities of daily living, including help in walking, getting in and out of bed, bathing, dressing, eating and taking medications
- Periodic turning and positioning in bed
- General supervision of exercises which have been taught to the patient, including the actual carrying out of a maintenance program

No benefits are paid in the following instances:

- After you have reached the maximum level of recovery possible for your particular condition, and you no longer require definitive treatment other than routine supportive care
- When confinement in a SNF is intended solely to assist you with the activities of daily living or to provide an institutional environment for convenience
- For treatment of alcoholism, drug addiction or mental illness
- For intermediate care or custodial care

The claims payor may periodically, at its own initiative or at the request of the PEBTF, re-evaluate the medical necessity (or other criteria for eligibility) of a SNF stay.

Wellness Benefit

The managed care plans offer a variety of wellness programs designed to assist you in attaining a healthy lifestyle. Wellness benefits may include health club membership discount programs, health education, smoking cessation and weight loss programs. Benefits vary among plans. Please contact your health plan for specific wellness benefits.

For additional information please see the various Medical Plan sections.

PREFERRED PROVIDER ORGANIZATION (PPO) OPTION

Non-Medicare Eligible Retirees

There are two PPO plans available – the Choice PPO and the Basic PPO. Each plan covers the same medically-necessary services as set forth by the REHP. The difference is in the annual deductible.

Summary

- Deductibles differ between Choice PPO and the Basic PPO
- PPO offers both an in-network and an out-of-network benefit
- In order to receive the highest level of benefits, you must choose one of the in-network physicians or facilities
- You may self refer for medically necessary care, as defined by the plan
- \$20 copayment for PCP office visits (for general practitioners, family practitioners, internists and pediatricians);
- \$45 copayment for specialist office visit
- \$50 copayment for urgent care visit
- \$200 copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)
- Plan coverage for services rendered by out-of-network providers is based on the Usual, Customary and Reasonable (UCR) charge or plan allowance, as determined by the claims payor. Payment of amounts in excess of the UCR charge or plan allowance are your responsibility

Benefit Highlights - Choice PPO Option

	Network Providers	Out-of-Network Providers **
DEDUCTIBLE (per calendar year) Annual in-network Deductible must be paid first for the following services: Hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), imaging, skilled nursing facility care and home health care.	\$400 single \$800 family	\$800 single \$1,600 family

	Network Providers	Out-of-Network Providers **
MEDICAL OUT-OF-POCKET MAXIMUM (per calendar year)	\$400 single \$800 family Plus copayments	Deductible \$800 single/ \$1,600 family 30% coinsurance of the next \$11,900 single/ \$23,800 family after which the plan pays at 100%
COMBINED OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period.	\$8,150 single \$16,300 family <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i> Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	\$8,150 single \$16,300 family <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i> Includes deductibles, coinsurance and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for non-network providers but it does include out-of-network cost sharing.
PREVENTIVE CARE		
See <i>Benefits Under All Non-Medicare Health Plan Options</i> section for a list of preventive benefits	Covered 100%	70% plan payment; Member pays 30%
MATERNITY SERVICES		
• Office visits	Covered 100% including first prenatal visit	70% plan payment; Member pays 30%
• Hospital and newborn care	Covered 100% after Deductible	70% plan payment; Member pays 30%

	Network Providers	Out-of-Network Providers **
PHYSICIAN VISITS		
<ul style="list-style-type: none"> Office visits (family practice, general practice, internal medicine and pediatrics) 	\$20 Copayment per office visit	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Specialist office visits 	\$45 Copayment per office visit	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery and anesthesia 	Covered 100% after Deductible	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Diagnostic tests (lab) 	Covered 100% at Quest Diagnostics or LabCorp; \$30 lab Copayment elsewhere	70% plan payment; Member pays 30%
OUTPATIENT THERAPIES		
<ul style="list-style-type: none"> Outpatient physical & occupational therapy Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) Cardiac rehabilitation (18 visits per year) Pulmonary rehabilitation (12 visits per year) Respiratory therapy Manipulation therapy (restorative, chiropractic – 6 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition) 	\$20 Copayment per visit	70% plan payment; Member pays 30%
OTHER PROVIDER SERVICES		
<ul style="list-style-type: none"> Radiation therapy, chemotherapy, kidney dialysis (not covered at a Non-Network freestanding dialysis center) Home Health Care Outpatient Private Duty Nursing (240 hours per year/8 hours per day) Skilled Nursing Facility (240 days per year) 	Covered 100% after Deductible	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Hospice 	Covered 100%	70% plan payment; Member pays 30%
OUTPATIENT HOSPITAL FACILITIES		
<ul style="list-style-type: none"> Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in a Non-Network freestanding dialysis center – is covered at a Non-Network rate if it is a Non-Network hospital), anesthesia & surgery 	Covered 100% after Deductible	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Outpatient Diabetic Education 	Covered 100%	Not covered

	Network Providers	Out-of-Network Providers **
INPATIENT HOSPITAL SERVICES		
<ul style="list-style-type: none"> Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for most services) 	Covered 100% after Deductible (365 days per benefit period)	70% plan payment; Member pays 30% Out-of-Network: 70 days per calendar year
EMERGENCY CARE		
<ul style="list-style-type: none"> Urgent care 	\$50 Copayment	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Emergency treatment for accident or medical emergency 	\$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived	
<ul style="list-style-type: none"> Ambulance services for emergency care 	Covered 100%; Deductible waived	Covered 100%; Deductible waived
INVISIBLE PROVIDERS AT A NETWORK FACILITY		
<ul style="list-style-type: none"> Includes radiologists, anesthesiologists, pathologists and emergency room physicians operating in a Network facility 	Covered same as Network Provider; Covered 100% after Deductible	
DURABLE MEDICAL EQUIPMENT		
<ul style="list-style-type: none"> Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics. The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics and supplies 	Not covered by the medical plan; covered by DMension Benefit Management, in accordance with the PEBTF DME policy unless dispensed and billed by a physician's office, emergency room, home health care agency, infused medicine provider, skilled nursing facility or Hospice and/or participating freestanding dialysis facility then the medical plan pays 100% after Deductible	
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

Benefit Highlights - Basic PPO Option

	Network Providers	Out-of-Network Providers * **
DEDUCTIBLE (per calendar year) Annual in-network Deductible must be paid first for the following services: Hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), imaging, skilled nursing facility care and home health care.	\$1,500 single \$3,000 family	\$3,000 single \$6,000 family
MEDICAL OUT-OF-POCKET MAXIMUM (per calendar year)	\$1,500 single \$3,000 family Plus copayments	Deductible \$3,000 single/\$6,000 family 30% coinsurance of the next \$11,900 single/\$23,800 family after which the plan pays at 100%
COMBINED OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period.	\$8,150 single \$16,300 family <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i> Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	\$8,150 single \$16,300 family <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i> Includes deductibles, coinsurance and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for non-network providers but it does include out-of-network cost sharing.

	Network Providers	Out-of-Network Providers * **
PREVENTIVE CARE		
See Benefits Under All Non-Medicare Health Plan Options section for a list of preventive benefits	Covered 100%	70% plan payment; Member pays 30%
MATERNITY SERVICES		
<ul style="list-style-type: none"> Office visits 	Covered 100% including first prenatal visit	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Hospital and newborn care 	Covered 100% after Deductible	70% plan payment; Member pays 30%
PHYSICIAN VISITS		
<ul style="list-style-type: none"> Office visits (family practice, general practice, internal medicine and pediatrics) 	\$20 Copayment per office visit	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Specialist office visits 	\$45 Copayment per office visit	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery and anesthesia 	Covered 100% after Deductible	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Diagnostic tests (lab) 	Covered 100% at Quest Diagnostics or LabCorp; \$30 lab Copayment elsewhere	70% plan payment; Member pays 30%
OUTPATIENT THERAPIES		
<ul style="list-style-type: none"> Outpatient physical & occupational therapy Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) Cardiac rehabilitation (18 visits per year) Pulmonary rehabilitation (12 visits per year) Respiratory therapy Manipulation therapy (restorative, chiropractic – 6 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition) 	\$20 Copayment per visit	70% plan payment; Member pays 30%

	Network Providers	Out-of-Network Providers * **
OTHER PROVIDER SERVICES		
<ul style="list-style-type: none"> Radiation therapy, chemotherapy, kidney dialysis (not covered at a Non-Network freestanding dialysis center) Home Health Care Outpatient Private Duty Nursing (240 hours per year/8 hours per day) Skilled Nursing Facility (240 days per year) 	Covered 100% after Deductible	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Hospice 	Covered 100%	70% plan payment; Member pays 30%
OUTPATIENT HOSPITAL FACILITIES		
<ul style="list-style-type: none"> Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in a Non-Network freestanding dialysis center – is covered at a Non-Network rate if it is a Non-Network hospital), anesthesia & surgery 	Covered 100% after Deductible	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Outpatient Diabetic Education 	Covered 100%	Not covered
INPATIENT HOSPITAL SERVICES		
<ul style="list-style-type: none"> Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for most services) 	Covered 100% after Deductible (365 days per benefit period)	70% plan payment; Member pays 30% Out-of-Network: 70 days per calendar year
EMERGENCY CARE		
<ul style="list-style-type: none"> Urgent care 	\$50 Copayment	70% plan payment; Member pays 30%
<ul style="list-style-type: none"> Emergency treatment for accident or medical emergency 	\$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived	
<ul style="list-style-type: none"> Ambulance services for emergency care 	Covered 100%; Deductible waived	Covered 100%; Deductible waived
INVISIBLE PROVIDERS AT A NETWORK FACILITY		
<ul style="list-style-type: none"> Includes radiologists, anesthesiologists, pathologists and emergency room physicians operating in a Network facility 	Covered same as Network Provider; Covered 100% after Deductible	

	Network Providers	Out-of-Network Providers * **
DURABLE MEDICAL EQUIPMENT		
<ul style="list-style-type: none"> Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics. The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics and supplies 	Not covered by the medical plan; covered by DMEnson Benefit Management, in accordance with the PEBTF DME policy unless dispensed and billed by a physician's office, emergency room, home health care agency, infused medicine provider, skilled nursing facility or Hospice and/or participating freestanding dialysis facility then the medical plan pays 100% after Deductible	
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

NOTE: All benefits are limited to Covered Services that are determined by the PPO to be Medically Necessary.

* **Basic PPO:** Benefits provided by non-participating providers are not covered. These providers include, but are not limited to, the following: Physicians, inpatient and outpatient providers such as ambulatory surgical facilities, freestanding dialysis facilities, long-term acute care hospitals, pharmacy/medical suppliers and substance abuse treatment programs.

** Participating providers agree to accept the PPO plan allowance as payment in full, often less than their normal charge. If you visit a non-participating provider, you are responsible for paying the deductible, coinsurance and the difference between the provider's charge and the plan allowance.

Inpatient admission and certain other services may require preauthorization. When care is rendered by a network provider, it is the responsibility of the hospital or physician to obtain preauthorization if it is required for the service being provided. Neither you nor your eligible dependent is required to obtain preauthorization when being treated by a network physician or in a PPO network hospital or other PPO network facility.

If you or your dependents receive or plan to receive services from an out-of-network provider who recommends services, it is your responsibility to obtain preauthorization from your plan. See the section below on Care or Treatment Requiring Preauthorization. You must call the plan and provide the following information:

- Your name and the name of the person for whom the services will be rendered
- Your PPO ID number
- Your physician's name
- Diagnosis of your illness, injury, or condition
- Name of the facility in which you will receive treatment
- Medical/surgical treatment you will receive or reason for your admission to the facility

IMPORTANT NOTE: In the chart that appears on the preceding pages, all benefit payment percentages are based on "eligible expenses." Eligible expenses are expenses for covered services that do not exceed the plan allowance for the service as determined by the PPO (the "claims payor"). You are responsible for all costs in excess of the plan allowance.

You can save money by using a PPO network provider. Network providers, sometimes called participating providers have agreed to accept the PPO's allowance as payment in full - often less than their normal charge. Since network providers charge no more than the plan allowance, by using these providers you can avoid the possibility of unexpected charges in excess of the plan allowance. If you use an out-of-network provider, you are responsible for the deductible, applicable coinsurance and all amounts in excess of the plan allowance.

Non-Network or Out-of-Network Services

Choice PPO: Each year, you pay the first \$800 (the deductible) of covered out-of-network expenses for each covered person/\$1,600 for family.

Basic PPO: Each year, you pay the first \$3,000 (the deductible) of covered out-of-network expenses for each person/\$6,000 for family

After the deductible, the PPO plan will pay 70% of the next \$11,900 single/\$23,800 family of most out-of-network covered expenses. Once you reach the out-of-pocket maximum, the plan pays 100% of covered expenses for the rest of the year. The combined out-of-pocket maximum is \$8,150 single/\$16,300 family. This includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between the brand and generic does not apply). Please refer to the above summary chart for more information.

NOTE: Covered expenses do not include charges in excess of the plan allowance for a service or supply as determined by the PPO. The percentage reimbursement described in the Benefit Highlights Chart for out-of-network providers is based on the plan allowance. For example, a "70% plan payment" for out-of-network providers means 70% of the plan allowance. You are responsible for paying the entire amount of the charge in excess of the plan allowance (as applicable), in addition to any deductible or coinsurance.

For out-of-network care, there is an unlimited lifetime maximum benefit.

All claims for out-of-network services must be filed on forms provided by the PPO. All claims must be filed with the PPO and postmarked no later than one year from the date of service. Please contact the PPO's phone number on your ID card for more information.

Care or Treatment Requiring Preauthorization

Preauthorization is an advance review of your proposed treatment to ensure it is medically necessary. **Preauthorization does not verify that you are covered by the plan nor does it guarantee payment.** All inpatient admissions and certain outpatient procedures require prior approval before they are performed.

Preauthorization requirements do not apply to services provided by a hospital Emergency Room provider. If an inpatient admission results from an Emergency Room visit, notification must occur within 48 hours or two business days of the admission. If the hospital is a network provider, the hospital is responsible for performing the notification. If the hospital is an out-of-network provider, you or your responsible party acting on your behalf are responsible for the notification.

The telephone number for preauthorization appears on your PPO ID card. Present your ID card to your health care provider. A network provider will obtain preauthorization. If you use an out-of-network provider or a BlueCard participating provider (Basic PPO Members), it is your responsibility to obtain preauthorization.

If the network provider fails to obtain or follow the preauthorization requirement, the plan allowance will not be subject to reduction. If you use an out-of-network provider and preauthorization is not obtained, the amount that would be paid for the medically necessary service is subject to a reduction of 20 percent as a penalty for failure to preauthorize.

Care Outside of the Plan's Network Area/Student Benefits

The PPO provides an out-of-area benefit for you and your eligible dependents.

Choice PPO Members: Aetna has a national network of providers. While you must reside in the plan's service area to enroll in the Choice PPO, you are able to visit providers outside of your area. Contact the plan for information about providers outside of your area.

Basic PPO Members: With the BlueCard Program, PPO members can enjoy in-network coverage anywhere in the United States when they use Participating Blue Cross and/or Blue Shield PPO providers.

To access BlueCard providers, call 1-800-810-BLUE (2583). The telephone number is printed on the back of your ID card.

BlueCard® Program

Under the BlueCard® Program, when members access covered services within the geographic area served by a Host Blue, Highmark will remain responsible to the group for fulfilling Highmark's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for contracting with and handling substantially all interactions with its participating health care providers.

Whenever members access covered services outside the area Highmark serves and the claim is processed through the BlueCard Program, the amount members pay for covered services is calculated based on the **lower** of:

- The billed charges for covered services, or
- The negotiated price that the Host Blue makes available to Highmark.

Often, this "negotiated price" will be a simple discount which reflects the actual price that the Host Blue pays to the member's health care provider. Sometimes, it is an estimated price that takes into account special arrangements with the health care provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modification noted above. However, such adjustments will not affect the price Highmark uses for the claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods including a surcharge, Highmark would then calculate member liability for any covered services according to applicable law.

Care Outside of the Country

Choice PPO Members: Coverage is available out of the country for urgent/emergency services. Also, coverage for follow-up care for the condition treated during the emergency/urgent visit will be covered. You should seek care at the nearest facility and contact Aetna as soon as possible. If the provider requires payment up front, you may submit any claims to Aetna for processing.

Basic PPO Members: BlueCard Worldwide provides members with access to network health care services around the world. Members traveling or residing outside of the United States have access to doctors and hospitals in more than 200 countries and territories.

Members who are traveling outside the United States should remember to always carry their PPO identification card. If non-emergency care is needed, Members may call 1-800-810-BLUE (2583). A medical coordinator, in conjunction with a medical professional, will assist members in locating appropriate care. The BlueCard Worldwide Service Center is staffed with multilingual representatives and is available 24 hours a day, 7 days a week. Also, members may call the plan to obtain preauthorization if services require preauthorization. BlueCard participating providers are not obligated to request preauthorization of services. Obtaining preauthorization, where required, is the member's responsibility (the preauthorization telephone number is on the back of your medical ID card).

Members who need emergency care should go to the nearest hospital. If admitted, members should call the BlueCard Worldwide Service Center, 1-800-810-BLUE (2583).

To locate BlueCard participating providers outside of the United States, members may call BlueCard Worldwide Service Center, 1-800-810-BLUE (2583), 24 hours a day, 7 days a week, or visit www.bcbs.com.

Filing a PPO Option Claim

All claims for out-of-network services must be filed on forms provided by the PPO. The claims must be filed with the PPO and postmarked no later than one year from the date of service. Please contact the PPO's phone number on your ID card for more information.

If your claim for benefits is denied, see page 100 for a description of the appeals process.

For additional information, please refer to the following sections: Benefits under all Non-Medicare Health Plan Options and Services Excluded From all Medical Benefit Options.

HEALTH MAINTENANCE ORGANIZATION (HMO) OPTION

Non-Medicare Eligible Retirees

Summary

- The HMO is a Custom HMO which offers a limited network of providers and facilities
- HMOs cover medical services as set for by the REHP
- Treatment for medical services is coordinated by a Primary Care Physician (PCP)
- \$5 copayment for PCP office visits during regular hours (for general practitioners, family practitioners, internists and pediatricians)
- \$10 copayment for specialist office visit
- \$50 copayment for urgent care visit
- \$150 copayment for Emergency Room visit (waived if the visit leads to an inpatient admission to the hospital)

HMO Provider Networks

HMOs have contracts with certain physicians and licensed medical professionals. HMOs also have contracts with certain hospitals and medical facilities. These groups form HMO networks from which you receive medical services. Each HMO has its own network of doctors and hospitals.

HMOs pay for services only if the services are rendered by a provider or facility which is in the HMO network. There is no coverage for services received outside of the network.

Primary Care Physician

You must choose a Primary Care Physician (PCP) from the network of HMO doctors. Your PCP acts as your personal physician, providing treatment or referring you to a network specialist or network hospital when needed. Care provided or coordinated by your PCP is considered **in-network**. Some HMOs do not require PCP referrals (check with your plan). Women may self refer for all gynecological care.

For your PCP, you may choose a general or family practitioner, internist or pediatrician. Each eligible member of your family may have a different PCP.

If your PCP is not available or refuses to provide care or a referral to a specialist in the network, you should contact the Member Services Department of your HMO. You may request to change your PCP by calling or writing your HMO's Member Services Department. The effective date of the change will depend on the date you notify Member Services.

Failure to receive authorization for services from the HMO and/or your PCP will result in non-payment of those services.

Benefit Highlights - HMO Option

Network Providers	
DEDUCTIBLE (per calendar year)	None
OUT-OF-POCKET MAXIMUM <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i>	\$8,150 single \$16,300 family Includes Deductibles, coinsurance, Copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Non-Network providers and other Out-of-Network cost sharing
PREVENTIVE CARE	
See Benefits Under All Non-Medicare Health Plan Options section for a list of preventive benefits	Covered in full
MATERNITY SERVICES	
• Office visits	Covered in full including first prenatal visit
• Hospital and newborn care	Covered in full
PHYSICIAN VISITS	
• Office visits (PCPs include family practice, general practice, internal medicine and pediatrics)	\$5 Copayment per office visit;
• Specialist office visits	\$10 Copayment per office visit
• Lab tests, X-rays, inpatient visits, surgery and anesthesia	Covered in full
Network Providers	
OUTPATIENT THERAPIES	
<ul style="list-style-type: none"> • Outpatient physical & occupational therapy • Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) • Cardiac Rehabilitation • Pulmonary Rehabilitation • Respiratory therapy • Manipulation therapy (restorative, chiropractic Medically Necessary visits; not for maintenance of a condition) 	\$5 Copayment per visit Combined Maximum of 60 visits per year for all outpatient therapies (Therapy services are considered visits. If the same provider performs different types of therapies on the same date, to the same Member, it counts as one visit for each type of therapy performed.)

	Network Providers
OTHER PROVIDER SERVICES	
<ul style="list-style-type: none"> • Radiation therapy, chemotherapy, kidney dialysis • Home Health Care (60 visits in 90 days) • Hospice • Skilled Nursing Facility (180 days per calendar year) 	Covered in full
OUTPATIENT HOSPITAL SERVICES	
<ul style="list-style-type: none"> • Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis, anesthesia & surgery • Outpatient Diabetic Education 	Covered in full
INPATIENT HOSPITAL SERVICES	
<ul style="list-style-type: none"> • Professional fees & facility services including: room & board & other Covered Services 	Covered in full (365 days per calendar year)
EMERGENCY CARE	
<ul style="list-style-type: none"> • Urgent care 	\$50 Copayment
<ul style="list-style-type: none"> • Emergency treatment for accident or medical emergency 	\$150 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital)
<ul style="list-style-type: none"> • Ambulance services for emergency care 	Covered in full
DURABLE MEDICAL EQUIPMENT	
<ul style="list-style-type: none"> • Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics. The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics and supplies 	Not covered by the medical plan; covered by DMension Benefit Management, in accordance with the PEBTF DME policy unless dispensed and billed by a physician's office, emergency room, home health care agency, infused medicine provider, skilled nursing facility or Hospice and/or participating freestanding dialysis facility
LIFETIME MAXIMUM BENEFIT	Unlimited

NOTE: All benefits are limited to covered services that are determined by the HMO (the "claims payor") to be medically necessary.

Care or Treatment Requiring Preauthorization

Preauthorization is an advance review of your proposed treatment to ensure it is medically necessary. **Preauthorization does not verify that you are covered by the health plan or guarantee payment.** All inpatient admissions and certain outpatient referrals and procedures require approval before they are performed.

Care Outside of the HMO Area

You must reside in the service area to enroll in an HMO. The HMO plan offered by the REHP is a Custom HMO and offers a limited network of providers and facilities. Emergency care only is covered outside of the service area. Seek emergency care and contact the plan. If you have a dependent who resides outside of the HMO's service area, he/she will have emergency care coverage only and would have to return to the service area for all other medical care; therefore you may want to enroll in a PPO.

Care Outside of the Country – Emergency Care

If you are traveling outside of the United States, you should remember to always carry your HMO identification card. There may be instances where a medical facility in a foreign country will recognize the HMO as providing payment for services. If the out-of-country medical facility does not recognize your HMO, you will probably be required to pay for medical services. You may then submit your claims to the HMO when you return home. You should ask for an invoice that includes your diagnosis and is translated into American dollars. Under the HMO option, benefits for services obtained out-of-network are generally limited to emergency situations.

Filing an HMO Option Claim

All claims for benefits under the HMO option must be filed with the HMO and postmarked no later than one year from the date of service.

If your claim for benefits is denied, see page 100 for a description of the appeals process.

For additional information, please refer to the following sections: Benefits under all Non-Medicare Health Plan Options and Services Excluded From all Medical Benefit Options.

MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM (MHSAP)

Non-Medicare Eligible Retirees

The Mental Health and Substance Abuse Program (MHSAP) applies to non-Medicare eligible retirees and eligible dependents regardless of when they retired.

Summary

The MHSAP will provide mental health and substance abuse rehabilitation treatment services, whether inpatient or outpatient. (**Inpatient detoxification services will be coordinated by the plan but services are covered under the PPO, HMO options, when clinically necessary.**)

The MHSAP provides a specialized network of professional providers and treatment facilities which have been evaluated according to comprehensive guidelines established by the MHSAP. The claims payor's network providers have not only fulfilled its specific selection and credentialing criteria, but are committed to your health and well-being.

You should experience lower out-of-pocket expenses and no claim forms as long as you use MHSAP in-network providers. However, PPO members have the freedom to receive eligible mental health and substance abuse services from out-of-network providers, but at a lower level of benefit coverage.

Under mental health parity, psychological conditions must be treated the same as physical illnesses. There are no visit limits under the MHSAP. Out-of-pocket costs are not higher under the MHSAP and there are no separate deductibles. The MHSAP will work with your specific medical plan option to track any deductibles that may apply to both medical and mental health and substance abuse treatment. You will not have two deductibles to satisfy under the PPO option. Medical and mental health and substance abuse benefits will both apply to the deductibles.

The MHSAP benefit will continue to be separate from your medical plan but the MHSAP will be structured the same as your medical plan option. The following pages detail the MHSAP benefits for members under all medical plan options. Please refer to the applicable chart that highlights the mental health and substance abuse benefits for the medical plan option in which you are enrolled.

**Benefit Highlights – MHSAP Benefit
For Members Enrolled in the Choice PPO Option**

Service	Network	Non-Network
DEDUCTIBLE (per calendar year)	\$400 single \$800 family	\$800 single \$1,600 family
OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% until the end of the benefit period <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i>	\$8,150 single \$16,300 family Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	\$8,150 single \$16,300 family Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Non-Network providers but it does include Out-of-Network cost sharing
MENTAL HEALTH		
Outpatient	100% after \$20 copayment	70% plan payment; Member pays 30% after deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Inpatient & Intermediate*	100% after deductible One physician visit per covered day unless covered by per diem	70% plan payment; Member pays 30% After deductible Subject to retrospective review
SUBSTANCE ABUSE		
Outpatient	100% after \$20 copayment	70% plan payment; Member pays 30% After deductible

Service	Network	Non-Network
Inpatient	100% after deductible	70% plan payment; Member pays 30% After Deductible
Ambulatory Detoxification	100% after deductible	70% plan payment; Member pays 30% After Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	\$200 copayment, waived if the visit leads to an inpatient admission	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

**Benefit Highlights – MHSAP Benefit
For Members Enrolled in the Basic PPO Option**

Service	Network	Non-Network
DEDUCTIBLE (per calendar year)	\$1,500 single \$3,000 family	\$3,000 single \$6,000 family
OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% until the end of the benefit period <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i>	\$8,150 single \$16,300 family Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	\$8,150 single \$16,300 family Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Non-Network providers but it does include Out-of-Network cost sharing

Service	Network	Non-Network
MENTAL HEALTH		
Outpatient	100% after \$20 copayment	70% plan payment; Member pays 30% After deductible Limited to licensed psychiatrists, psychologists, social workers and nurses Subject to retrospective review
Inpatient & Intermediate*	100% after deductible One physician visit per covered day unless covered by per diem	70% plan payment; Member pays 30% After deductible Subject to retrospective review
SUBSTANCE ABUSE		
Outpatient	100% after \$20 copayment	70% plan payment; Member pays 30% After deductible
Inpatient	100% after deductible	70% plan payment; Member pays 30% After deductible
Ambulatory Detoxification	100% after deductible	70% plan payment; Member pays 30% After Deductible
Medical Detoxification	Covered by medical plan	
EMERGENCY ROOM	\$200 copayment, waived if the visit leads to an inpatient admission	
* Intermediate care includes partial hospitalization, day treatment and intensive outpatient		

**Benefit Highlights – MHSAP Benefit
For Members Enrolled in the HMO Option**

Service	Network
DEDUCTIBLE (per calendar year)	None
OUT-OF-POCKET MAXIMUM When the Out-of-Pocket Maximum is reached, the plan pays at 100% until the end of the benefit period <i>Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).</i>	\$8,150 single \$16,300 family Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.
MENTAL HEALTH	
Outpatient	100% after \$5 copayment
Inpatient & Intermediate*	100% One physician visit per covered day unless covered by per diem
SUBSTANCE ABUSE	
Outpatient	100% after \$5 copayment
Inpatient	100%
Ambulatory Detoxification	100%
Medical Detoxification	Covered by medical plan
EMERGENCY ROOM	\$150 copayment, waived if the visit leads to an inpatient admission
*Intermediate care includes partial hospitalization, day treatment and intensive outpatient	

NOTE: Usual, Customary and Reasonable (UCR) charges for services are determined by the Claims Payor for the MHSAP. You are responsible for all costs in excess of UCR charges.

Services for Mental Health and Substance Abuse Disorders

Subject to applicable Deductibles, Copayments, and Coinsurance, as described in the medical plan sections, coverage is provided for the following services for the treatment of mental illness and substance abuse disorders that is received as Inpatient treatment, residential treatment, partial hospitalization/day treatment, intensive Outpatient treatment, or other Outpatient treatment (including treatment in a Provider's office) and where the services are provided by or under the direction of a properly qualified behavioral health Provider:

- (a) Diagnostic evaluations, assessment and treatment planning
- (b) Treatment and/or procedures
- (c) Medication management and other associated treatments
- (d) Individual, family, and group therapy
- (e) Provider-based case management services
- (f) Crisis intervention
- (g) Ambulatory detoxification

Medical detoxification shall be provided through your Medical Plan Option. Provider referrals, coordination of care and other administrative services relating to such treatment shall be provided by a person specifically designated by the applicable Mental Health Benefits Manager for the administration of services for mental health and substance abuse disorders.

Behavioral Health Virtual Visits

You may talk and see a mental health provider online, in the privacy and comfort of your own home. Virtual visits are a convenient option for members who have busy schedules, have difficulty getting to appointments or where it may be a distance to visit a provider. Log on to ***Liveandworkwell.com***, 24/7 with your smart phone or computer.

Prior Authorization for Mental Health and Substance Abuse Treatment

Prior authorization is required for the following services provided for the treatment of Mental Illness or a substance abuse disorder.

- (a) Inpatient admission, including admission to a residential treatment facility
- (b) Partial hospitalization/day treatment
- (c) Intensive Outpatient treatment
- (d) Psychological testing
- (e) Outpatient treatment visits in excess of 50 minutes, with or without medication management
- (f) Transcranial magnetic stimulation
- (g) Intensive behavioral therapy

If your behavioral health Provider is In-Network, the Provider will be responsible for obtaining the authorization. If your behavioral health Provider is Out-of-Network (applicable only if enrolled in PPO Option, you are responsible for obtaining the authorization; Out-of-Network services are not covered if enrolled in the HMO Option). In the event of an

emergency, notice to the In-Network Provider or the Mental Health Benefits Manager must be made as soon as reasonably possible.

If you use a Non-Network or Non-Participating Provider and preauthorization is not obtained, the amount that would be paid for the clinically necessary service is subject to a reduction of 20% as a penalty for failure to preauthorize.

Coverage for Autism Spectrum Disorders

Benefits for Autism Spectrum Disorders will be provided by the REHP medical plans, the Mental Health and Substance Abuse Program and the REHP Prescription Drug Plan. Benefits will not exceed an annual maximum benefit amount under all coverage combined.

Coverage is provided for dependent children and young adults to age 21 who have a diagnosis of Autism Spectrum Disorders. The coverage is in accordance with the Pennsylvania's Autism Insurance Act (Act 62 of 2008 – HR 1150). Autism Spectrum Disorders include: Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Development Disorder (Not Otherwise Specified).

Subject to the deductibles, copayments, and coinsurance applicable under your Medical Plan Option, coverage is provided for behavioral therapy, including intensive behavioral therapy such as applied behavioral analysis (ABA), provided that the therapy is:

- (a) Focused on the treatment of core deficits of the Member's autism spectrum disorder and maladaptive/stereotypic behaviors that are posing a danger to the Member himself or herself, to others, or to property or that impair the Member's daily functioning.
- (b) Provided by a Board Certified Applied Behavioral Analyst or other qualified provider, acting in accordance with an appropriate treatment plan prescribed by the Member's physician.

Prior authorization is required for ABA and other forms of intensive behavioral therapy. Medical treatment of the autism spectrum disorder, apart from this behavioral treatment, shall be covered in accordance with the terms of your Medical Plan Option.

Emergency Services

If you or an eligible dependent experience a mental health or substance abuse emergency, immediately proceed to the nearest Emergency Room or medical facility. You or a family member should advise the facility that you are an REHP member with mental health and substance abuse benefits administered separately from your health plan. Ask the facility or the person providing your care to contact the MHSAP as soon as possible so that the plan can effectively coordinate with your medical doctor or facility the mental health or substance abuse treatment you will need.

Filing an MHSAP Option Claim

All claims for benefits under the MHSAP option must be filed with the MHSAP and postmarked no later than one year from the date of service.

If your claim for benefits is denied, see page 100 for a description of the Appeals Process.

SERVICES EXCLUDED FROM ALL BENEFIT OPTIONS

Non-Medicare Eligible Members

The plans do not cover services, supplies or charges for:

- Abortions, unless necessary to save the life of the mother or in the case of rape or incest (documentation will be requested)
- Activity therapy, mainstreaming and similar treatment
- Acupuncture
- Adult immunizations and immunizations for travel or employment, except the adult immunizations approved for coverage (see Benefits Under all Non-Medicare Health Plan options section)
- Any other medical or dental services or treatment except as provided in the Plan
- Automotive adaptations
- Autopsy
- Balances for brand-name prescription drugs obtained when FDA approved generic is available
- Braces and supports needed for athletic participation or employment
- Care related to autistic disease of childhood above the annual limit and for members age 21 and over, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation that extends beyond traditional medical management, or for inpatient confinement for environmental change
- Charges associated with transportation of blood, blood components or blood products
- Charges for blood donors with blood donation
- Charges in excess of UCR charge or plan allowance as determined by the claims payor
- Cognitive rehabilitative therapy
- Copayment for prescription drugs
- Correction of myopia, hyperopia or presbyopia by corneal microsurgery, laser surgery or other similar procedure such as, but not limited to, keratomileusis, keratophakia or radial keratotomy and all related services
- Corrective appliances that do not require prescription specifications and/or used primarily for sports

- Cosmetic surgery intended solely to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes (excluding surgery resulting from an accident while covered under this plan)
- Cranial prostheses (wigs)
- Custodial care, intermediate care, domiciliary care or rest cures
- Ecological or environmental medicine, diagnosis and/or treatment
- Enuresis alarm(s) training program or devices
- Equipment costs related to services performed on high cost technological equipment such as, but not limited to, computed tomography (CT) scanners, magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters, unless the acquisition of such equipment was approved through a Certificate of Need (CON) process, or was otherwise approved by the claims payor
- Equipment that does not meet the definition of Durable Medical Equipment in accordance with the claims payor's or REHP's medical policy, including personal hygiene or convenience items (air conditioner, air cleaner, humidifiers, adult diapers, fitness equipment, etc.)
- Estimates to repair a Durable Medical Equipment (DME) item
- Examinations or treatment ordered by the court in connection with legal proceedings unless such examinations or treatment otherwise qualify as covered services
- Examinations for employment, school, camp, sports, licensing, insurance, adoption, marriage, registration of domestic partnership, civil union or similar relationship, driver's license, foreign travel, passports or those ordered by a third party
- Expenses directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impaction, alveolectomy and treatment of periodontal disease; emergency dental services rendered within 72 hours of an accidental injury are covered under all medical plans (see Emergency Medical Services in Benefits Under All Non-Medicare Health Plan Options). The medical plans may provide coverage for anesthesia services for dental care rendered to a patient who is seven years of age or younger or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under general anesthesia
- Expenses for injury sustained or sickness contracted while engaged in the commission or attempted commission of an assault or felony for which you have not been acquitted
- Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury)

- Genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to plan guidelines, except what is covered under preventive benefits – see Section 2 for a list of preventive benefits
- Guest meals and accommodations
- Hearing exams or hearing aids
- Home services to help meet personal/family/domestic needs
- Hypnotherapy
- Illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit (e.g. Workers' Compensation)
- Illness or injury resulting from any act of war, whether declared or undeclared
- Injuries resulting from the maintenance or use of a motor vehicle if such treatment or services is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan or payable by the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law
- Injury or illness resulting from an automobile accident where the member failed to obtain automobile accident insurance as required by law
- Inpatient admissions primarily for physical therapy or diagnostic studies
- Local infiltration anesthetic
- Marriage counseling if not covered by the Mental Health and Substance Abuse Program
- Membership costs for health clubs, weight loss clinics or similar program, except as may be provided through your plan's wellness programs
- Mental health and substance abuse treatment services not covered by the managed Mental Health and Substance Abuse Program; the first visit to a non-mental health provider (one such visit per calendar year) is covered under the medical plan
- Morbid Obesity: For services and supplies for the surgical treatment of obesity, including Morbid Obesity, for components of the treatment of obesity or Morbid Obesity (including without limitation nutritional counseling, nutritional supplements, commercial weight loss programs, exercise equipment or gym membership), or for the performance of a panniculectomy (a surgical procedure to remove an unwanted fatty abdominal apron or panniculus), or other surgical procedure to remove excess skin as the result of weight loss, regardless of the reason or reasons such a procedure is recommended. Notwithstanding the foregoing sentence, the following services shall not be subject to this exclusion: (i) eligible services and supplies (incurred or obtained on and after July 1, 2005) with respect to a weight management program approved by the PEBTF; (ii) nutritional counseling that is covered as preventive care under the Preventive Care Section of the applicable medical plan option; and (iii) bariatric surgery (specifically limited to roux-en-y, gastric sleeve and biliopancreatic diversion and duodenal switch procedures), but only if the surgery meets each of the following criteria:

- 1) the surgery is authorized or certified in advance in accordance with the rules that apply to the pre-authorization or pre-certification of similar surgical procedures under the medical Plan Option in which the member on whom the procedure is to be performed ("Applicable Member") is enrolled
- 2) the surgery is otherwise covered under such Plan Option;
- 3) the surgery is performed by or within a Provider specifically designated by the Trustees as a "Center of Care" for the type of procedure performed;
- 4) the Applicable member has a diagnosis of Type 2 diabetes;
- 5) the Applicable Member has a body mass index of 40 or greater;
- 6) the Applicable member has attained the age of 18;
- 7) the Applicable Member has participated in and complied with a physician supervised multidisciplinary nutrition and exercise program for a minimum of six (6 months) in the twelve (12) month period that immediately precedes the scheduled surgery; and meets the medical necessity criteria set forth in the medical Plan Option in which the Applicable Member is enrolled;
- 8) the Applicable Member has undergone a complete psychological evaluation by an appropriate mental health professional within three (3 months) prior to the scheduled surgery;
- 9) the Applicable Member is able to understand and agrees to comply with lifelong follow up and lifestyle changes.

The exclusion will not apply to repeat or revised procedures that are performed specifically to correct complications from covered bariatric surgery provided that such repeat or revised procedures meet the same criteria as the initial surgery, including without limitation a requirement to obtain a new prior authorization for the repeat or revised procedure, and further provided that none of the failure by the Applicable Member to comply with one or more post-operative recommendations shall not provide a reason for a repeat or revised procedure to be approved unless the non-compliance results from complications of the surgery or other valid medical reasons.

- Music therapy
- Non-prescription items such as vitamins, nutritional supplements, liquid diets and diet plans, food supplements, bandages, gauze, etc. (enteral formula may be covered with certain diagnoses); some over-the-counter medications are covered – see the Prescription Drug Plan section
- Nutritional counseling (except for diabetic educational training and what is provided under your preventive benefits – see Section 2)
- Outpatient prescription drugs
- Over-the-counter cold pads/cold therapy and heat pads/packs

- Palliative or cosmetic foot care, including flat foot conditions, supportive devices for the foot, the treatment of subluxation of the foot, care of corns, bunions (except capsular or bone surgery) calluses, toenails, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet (routine diabetic foot care, except for gestational diabetes, is covered under all medical plans)
- PPO Option: Notwithstanding anything in the Plan to the contrary, no benefits shall be payable under the PPO Option for care provided by a non-contracted Provider. For these purposes, a non-contracted Provider is a Provider that has no agreement with (i) the Claims Payor that has established the applicable Network for the PPO Option, relating to payment for care rendered by that Provider, whether or not that agreement pertains to the Network; or (ii) any Blue Cross or Blue Shield Plan that would qualify the Provider for participation in the BlueCard Program
- Premarital blood tests
- Pre-operative care when the member is not an inpatient and post-operative care other than that normally provided following operative or cutting procedures
- Prescription drugs under all medical plans, except those administered to a member who is an inpatient and billed by the facility and those administered intravenously or by means of intramuscular or subcutaneous injection to a member by a physician or other medical professional in a physician's office and billed by the physician (certain injectable medications may be covered exclusively under the Prescription Drug Plan and may be ineligible for coverage under the medical plan)
- Primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy
- Private Duty Nursing while confined to a facility
- Reversal of voluntary sterilization
- Screening examinations including x-ray examinations made without film
- Sensitivity training, educational training therapy or treatment for an education requirement (except for diabetic educational training, which is covered under all plans)
- Service, supply or charge which are not provided by a Center of Care, as defined in Section 2, where the REHP has determined that such service, supply or charge will be covered only if provided by a Center of Care
- Services and charges for supplies incurred by a surrogate mother, intended parents and child relating to pregnancy and childbirth, whether the member is the surrogate mother or the intended parent. A surrogate mother is an individual who has contracted with an intended parent to bear a child as a surrogate mother with the intention of relinquishing the child, following birth, to the intended parent, and so who, in fact, relinquishes the child (all expenses of the first 31 days become the other parent's insurance expenses). This exclusion does not apply to services provided to a child after his birth, who is born for the benefit of a member by a surrogate mother, for services provided following a legal adjudication or custody or parentage by the member with respect to that child. A child born by a member who is acting as a surrogate mother will not be covered by the plan, except to the extent required by law

- Services and supplies determined to not be medically necessary by the claims payor, even if prescribed by a physician
- Services billed by unapproved providers: home health aides, non-licensed individuals (except for those providers approved under the Pennsylvania Autism Insurance Act (Act 62 of 2008), acupuncturists, naturopaths or homeopaths including those working under the direct supervision of an approved provider
- Services denied by a primary carrier for non-compliance with the primary plan
- Services for which you have no legal obligation to pay
- Services incurred before your coverage is effective or after your coverage ends
- Services of a provider that is not an eligible provider under the plan
- Services paid for by any government benefits
- Services performed by a family member (including, but not limited to, spouse/domestic partner, parent, child, in-laws, grandparent, grandchild, sibling)
- Services performed by a professional provider enrolled in an educational training program when such services are related to the education and training program and provided through a hospital or university (charges are usually part of the facility charges and cannot be billed separately)
- Services rendered by other than hospitals, physicians, facility other providers or other professional providers
- Services which are determined to be experimental or investigative by the claims payor
- Services which are not prescribed or performed by, or upon the direction of, a physician or other professional provider
- Sports medicine treatment plans, surgery, corrective appliances or artificial aids primarily intended to enhance athletic functions
- Telephone consulting, missed appointment fees or charges for completion of a claim form
- Therapy service which is not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition. By way of example, but not of limitation, therapy services provided primarily to maintain the patient's current condition rather than to improve it are excluded from coverage
- Tinnitus Maskers
- To the extent payment has been made under Medicare or would have been made if the member had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the member elects this coverage as primary
- Travel, even if recommended by your physician

- Treatment for sexual dysfunction not related to organic disease
- Treatment for temporomandibular joint (TMJ) syndrome with intra-oral prosthetic devices (splints) or any other method to alter vertical dimension
- Treatment, procedure or service related to infertility or assisted fertilization, and for fertilization techniques such as, but not limited to, artificial insemination, In-Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), and for all diagnostic services related to infertility or assisted fertilization
- Vision therapy
- Vocational therapy
- Xeloda, a prescription drug used as oral chemotherapy (NOTE: Xeloda may be covered under the Prescription Drug Plan)
- Any claim not properly and timely received within the time prescribed by the applicable plan option

This is a partial list of exclusions. If you have any questions about whether a particular expense is covered, you or your physician may contact the Claims Payor or the PEBTF.

WHAT ARE MY RESPONSIBILITIES?

Non-Medicare Eligible Retirees

Identification Cards

PPO or HMO Options: If you are enrolled in a PPO or HMO you received ID cards. If you are in an HMO, you must present the HMO's ID card to obtain services. If you are in a PPO and you are electing to receive treatment from a network provider, you must present the ID card to obtain services. If you are in a PPO and you are electing to receive treatment from an out-of-network provider, you may be asked to present your ID card to obtain services or you may need to provide a copy of your ID card when you submit the claim form requesting reimbursement. Check with your plan on how to submit out-of-network claims. The PPO or HMO ID card should be used until you transfer to other coverage or until you or your dependents are eligible for Medicare. Non-Medicare eligible dependents of a Medicare eligible retiree will remain in the plan selected by the retiree.

Prescription Drug Plan: You will also receive an REHP Prescription Drug Plan ID card. Present the ID card at a network-pharmacy when you need prescription drugs. The pharmacy will fill your prescription and charge you the appropriate copayment plus any balance due if you elect to buy a brand name drug when a generic is available.

NOTE: If you obtain prescription drugs from a pharmacy which does not participate with the prescription benefit manager, you will have to pay for your prescriptions and then submit a claim to the Prescription Drug Plan using a Drug Claim Form. You may obtain a Drug Claim Form by contacting the PEBTF or the prescription benefit manager. Reimbursement will be made directly to you for the amount which would have been paid to a Participating pharmacy minus the applicable copayments and brand versus generic differential. The amount of your reimbursement will be based on the generic reimbursement rates, if applicable (see the REHP Prescription Drug Plan section for more information).

2020 REHP Benefit Option Summary Comparison -- Non-Medicare Eligible Retiree Members

BENEFIT	PPO CHOICE OPTION		PPO BASIC OPTION		HMO OPTION
	No Referrals Needed		No Referrals Needed		All care directed by Primary Care Physician (not all Plans)
	In Network	Out-of-Network	In Network	Out-of-Network	
Deductible	\$400 single/\$800 family	\$800 single/\$1,600 family	\$1,500 single/\$3,000 family	\$3,000 single/\$6,000 family	\$0
Out-of-Pocket Maximums (includes Deductibles, coinsurance, Copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for Non-Network providers but it does include Out-of-Network cost sharing)	\$8,150 single/\$16,300 family	\$8,150 single/\$16,300 family	\$8,150 single/\$16,300 family	\$8,150 single/\$16,300 family	\$8,150 single/\$16,300 family
Physician Visits					
Primary Care Physician	\$20 Copayment	70%* after Deductible; Member pays 30%	\$20 Copayment	70%* after Deductible; Member pays 30%	\$5 Copayment
Specialist	\$45 Copayment	70%* after Deductible; Member pays 30%	\$45 Copayment	70%* after Deductible; Member pays 30%	\$10 Copayment
Preventative Care					
Adult (see list in REHP Handbook)	100%	70%* after Deductible; Member pays 30%	100%	70%* after Deductible; Member pays 30%	100%
Pediatric (see list in REHP Handbook)	100%	70%* after Deductible; Member pays 30%	100%	70%* after Deductible; Member pays 30%	100%
Urgent Care	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment	\$50 Copayment
Emergency Room Services	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$200 Copayment, if considered a medical emergency as defined by the PPO (waived if admitted as an inpatient)	\$150 Copayment if considered a medical emergency as defined by the HMO (waived if admitted as an inpatient)
Hospital Expenses (Inpatient & Outpatient)	100% after Deductible (up to 365 days per year) Semi-private room (private room if Medically Necessary)	70%* after Deductible (up to 70 days per calendar year); Member pays 30%	100% after Deductible (up to 365 days per year) Semi-private room (private room if Medically Necessary)	70%* after Deductible (up to 70 days per calendar year); Member pays 30%	100%; semi-private room (private room if Medically Necessary)
Medical/Surgical Expenses Including Physician Services (except office visits)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%
Skilled Nursing Facility Care (medically necessary)	100% after Deductible (240 days per calendar year)	70%* (240 days) after Deductible; Member pays 30%	100% after Deductible (240 days per calendar year)	70%* (240 days) after Deductible; Member pays 30%	(180 days per calendar year at participating facility)
Home Health Care (medically necessary)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%; up to 60 visits in 90 days; may be renewed at the option of the HMO
Diagnostic Tests (Labs)	100% at Quest Diagnostics or LabCorp; \$30 lab Copayment elsewhere	70%* after Deductible; Member pays 30%	100% at Quest Diagnostics or LabCorp; \$30 lab Copayment elsewhere	70%* after Deductible; Member pays 30%	100%
Imaging (X-ray, MRI, CT, etc.)	100% after Deductible	70%* after Deductible; Member pays 30%	100% after Deductible	70%* after Deductible; Member pays 30%	100%
Outpatient Therapies - Such as Outpatient Physical and Occupational Therapy, Speech Therapy, and Chiropractic Care (restorative, medically necessary; not for maintenance of a condition)	\$20 Copayment	70%* after Deductible; Member pays 30%	\$20 Copayment	70%* after Deductible; Member pays 30%	\$5 Copayment
Mental Health & Substance Abuse Treatment	Provided by Optum	Provided by Optum	Provided by Optum	Provided by Optum	Provided by Optum
Durable Medical Equipment/Prosthetic	DMEnson Benefit Management		DMEnson Benefit Management		DMEnson Benefit Management
Out of the Area Care	Urgent and Emergency Care Only, or as defined by the PPO	70%* after Deductible; Member pays 30%	Urgent and Emergency Care Only, or as defined by the PPO	70%* after Deductible; Member pays 30% (Possible BlueCard)	Emergency Care Only, or as defined by the HMO
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* Non-participating/non-network providers may balance bill for difference between plan allowance and actual charge.

This Benefit Option Summary Comparison is for illustrative purposes only. It is not all inclusive nor definitive. The actual benefits are as set forth in the REHP Benefits Handbook.

MEDICARE ELIGIBLE RETIREES

SUMMARY OF AVAILABLE BENEFITS

Medicare eligible retirees and eligible dependents are enrolled in the Medicare Open Access PPO. The Medicare eligible member must be enrolled in Medicare Part A and Part B to be enrolled in one of these plans.

Medicare Open Access PPO

- Inpatient facility services (you must visit a provider who is eligible to receive Medicare payment and accepts your plan)
- Outpatient facility services (you must visit a provider who is eligible to receive Medicare payment and accepts your plan)
- Inpatient and outpatient medical-surgical services (you must visit a provider who is eligible to receive Medicare payment and accepts your plan)
- Fitness benefit

Contact the PEBTF if you are not eligible for Medicare Part A or Part B.

NOTE: Medicare regulations do not allow you to be enrolled in two Medicare Advantage Plans. If you have coverage through another employer or retiree group, you may want to contact that group to determine if you should enroll in one of the plans offered by the REHP. You may contact the PEBTF to discuss your enrollment options.

As a Medicare eligible REHP member, you are required to enroll in BOTH the REHP medical and prescription drug coverage OR decline both REHP medical and prescription drug coverage. You may enroll in only medical coverage if you are enrolled in PACE/PACENET, VA or TRICARE prescription drug coverage.

The Medicare Open Access PPO covers all the benefits of traditional Medicare and usually makes additional benefits available at a reduced or no cost. **You must be enrolled in Medicare Part A and Part B to be enrolled in one of these plans.** The Federal Government through the Centers for Medicare and Medicaid Services (CMS) oversees Medicare Advantage Plans, regulating the coverage that is provided. The Medicare Open Access PPO offered by the REHP is a Medicare Advantage plan. One of the aspects of CMS's regulations for REHP members is that you must be allowed to return to traditional Medicare Parts A and B at any time (this rule may not be applicable in the future). If you return to traditional Medicare Parts A and B, you will not have medical or prescription drug coverage under the REHP. Before enrolling, check with the Medicare Advantage Plan that you may be considering to ensure that you thoroughly understand your enrollment/disenrollment options. If you enroll in a Medicare Advantage Plan, you must continue to pay the Medicare Part B premium.

A brief time is required to process the disenrollment paperwork during which time you remain covered by the Medicare Advantage Plan. However, if you choose to opt out of REHP Medicare Open Access PPO coverage you may only have the option of re-enrolling one other time.

MEDICARE OPEN ACCESS PPO

(Medicare Eligible Members)

Summary – Medicare Open Access PPO

The Medicare Open Access PPO does not require the selection of a Primary Care Physician (PCP) to obtain medical services. Your providers must be eligible to receive Medicare payment and accept your plan.

- Annual deductible, which is the Medicare Part B deductible
- No specialist referral needed
- Preventive care covered at 100%
- Hospital expenses (unlimited hospital stays when medically necessary) – covered 100%
- Primary Care Physician (PCP) – \$20 copayment per visit for in-network care
- Specialist – \$30 copayment per visit for in-network care
- Emergency medical care – \$100 copayment per visit (waived if the visit leads to an inpatient admission to the hospital)
- Ambulance services – Covered 100% for Medicare covered ambulance services

Advantages of the Medicare Open Access PPO

The Medicare Open Access PPO offers:

- **Comprehensive Services** – Benefits include those provided through traditional Medicare but usually at much lower out of pocket costs. Some additional items are covered.
- **Coordinated Care** – You do not have to select a Primary Care Physician (PCP). However, it is always prudent to have one family doctor who is knowledgeable about and documents all of your medical treatments. Your provider must be eligible to receive Medicare payment accept your plan.
- **Low out-of-pocket Expenses** – You pay an annual in-network deductible, which equals the annual Medicare Part B deductible. Once you satisfy the annual deductible, you pay a \$20 copayment for a PCP office visit and a \$30 copayment for a Specialist office visit. Other services will be paid at 100% as indicated in the Benefit Highlights Chart. In addition, you must continue to pay the Medicare Part B premium, which is usually deducted from your Social Security check. Services you need from a hospital or other facility, such as rehabilitation or skilled nursing, are covered in full as long as the services are approved by your plan, subject to any plan limitations and annual maximums.
- **Little or No Paperwork** – In general, you will have no claim forms or other paperwork to complete or submit. You may have to submit a claim form if you have services out of the country.
- **Fitness Benefit** – The Medicare Open Access PPO plan offers a free fitness benefit, which is subject to change at the plan's discretion. Contact the plan for more information.

Eligibility and Enrollment Rules

Members must satisfy CMS and commonwealth requirements to be eligible for the Medicare Open Access PPO enrollment, including:

- Enrollment in Medicare Parts A and B and continued payment of the Part B monthly premium
- Residence within the Medicare Open Access PPO plan's service area

Any non-Medicare eligible dependents may remain enrolled in their current non-Medicare eligible health plan.

NOTE: Self-pay and \$5 State-Paid REHP retirees with two or more dependents, some of whom are Medicare eligible and some who are not, should contact the PEBTF for rate information. Survivor spouses/domestic partners are eligible for single coverage only.

Enrollment Procedures

- Enrollment in the Medicare Open Access PPO is processed through the plan. You will be automatically enrolled in the Medicare Open Access PPO when you qualify for Medicare.
- If CMS approves your enrollment, the Medicare Open Access PPO will notify you of your coverage effective date and you will be provided with the Medicare Open Access PPO ID card. Use the ID card for all medical services. Remember, you should retain your original Medicare ID card to use for other services such as senior discounts. The Medicare Open Access PPO will advise you, in writing, of its appeal procedures, rules, and other important administrative information.

The following Benefit Highlights Chart provides a summary of covered services. Please refer to your specific plan materials for more detailed information and a list of exclusions.

Benefit Highlights - Medicare Open Access PPO

Benefit	In and Out-of-Network
DEDUCTIBLE (per calendar year) The deductible must be met prior to benefits being payable.	Annual Medicare Part B deductible
OUT-OF-POCKET MAXIMUM (per calendar year) When the out-of-pocket maximum is reached, the PPO pays at 100% until the end of the benefit period	\$2,500 per person
LIFETIME MAXIMUM	
PREVENTIVE CARE	
Annual wellness	Covered 100%
Adult routine physical exam and preventive care (every 12 months)	Covered 100%
Medicare-covered immunizations – flu vaccine, pneumonia vaccine, Hepatitis B, NOTE: Shingles vaccine (Shingrix and Zostavax) covered according to Medicare guidelines under the Prescription Drug Plan with a copay	Covered 100%
Routine GYN visit (cervical and vaginal cancer screenings) One routine GYN visit and pap smear every 24 months	Covered 100%
Annual routine mammogram (for women age 40 and older)	Covered 100%
Bone mass measurement – for people at risk for osteoporosis (every 24 months)	Covered 100%
Colorectal cancer screening (age 50 or older or at high risk for colorectal cancer)	Covered 100%
Prostate cancer screening (for men age 50 or older, every 12 months)	Covered 100%
Additional Medicare-covered preventive services*	Covered 100%
PHYSICIAN SERVICES	
Primary Care Physician (PCP) office visits	\$20 copayment per visit (after deductible)
Specialist office visits	\$30 copayment per visit (after deductible)
Medicare covered podiatry services	\$30 copayment per visit (after deductible)
Allergy Testing/Treatment Visits	\$30 copayment per visit (after deductible)

Benefit	In and Out-of-Network
DIAGNOSTIC PROCEDURES	
Medically necessary x-rays	Covered 100% (after deductible)
Laboratory services	Covered 100%
HOSPITAL CARE	
Inpatient coverage (Semi-private room; private room if medically necessary)	Covered 100%; no limit to the number of days (after deductible)
Outpatient hospital expenses (includes surgery)	Covered 100% (after deductible)
MENTAL HEALTH CARE	
Inpatient mental health in a Medicare-participating psychiatric hospital	Covered 100% (unlimited lifetime days) (after deductible)
Outpatient mental health care	\$20 copayment for each Medicare covered individual or group therapy visit (after deductible)
Inpatient substance abuse	Covered 100%; no limit to the number of days covered each benefit period (after deductible)
Outpatient substance abuse	Covered 100% for Medicare covered individual or group visit (after deductible)
EMERGENCY SERVICES & URGENTLY NEEDED CARE	
Urgently needed care	\$50 copayment (waived if the visit leads to an inpatient admission to the hospital)
Emergency treatment for accident or medical emergency	\$100 copayment (waived if the visit leads to an inpatient admission to the hospital)
Ambulance service for emergency care	Covered 100% for Medicare covered ambulance service
OUTPATIENT REHABILITATION THERAPIES	
<ul style="list-style-type: none"> ▪ Physical ▪ Occupational ▪ Cardiac ▪ Speech (medical/not developmental) ▪ Pulmonary ▪ Medicare covered chiropractic services 	\$20 copayment per visit for each Medicare covered visit (after deductible)

Benefit	In and Out-of-Network
OTHER PROVIDER SERVICES	
Outpatient complex radiology, chemotherapy	Covered 100% (after deductible)
Outpatient dialysis	Covered 100%
Home Health Care	Covered 100% (after deductible)
Skilled nursing facility care	Covered 100% (100 days per benefit period) (after deductible)
Hospice	Covered by Medicare at a Medicare-certified Hospice Program
DURABLE MEDICAL EQUIPMENT (DME)/PROSTHETIC DEVICES DME includes wheelchairs, oxygen, etc. Prosthetic devices includes braces, artificial limbs and eyes, etc.	Covered 100% (after deductible)
DIABETIC SUPPLIES (Strips, lancets, insulin pumps and glucometer)	Covered 100%
HEARING SERVICES	Covered 100% for Medicare covered diagnostic hearing exams; one annual routine exam (subject to change at claims payor's discretion); hearing aids are not covered
VISION SERVICES	Covered 100% for Medicare covered annual screening such as screening for glaucoma
HEALTH & WELLNESS EDUCATIONAL PROGRAMS	Included
FITNESS BENEFIT	Included, which is subject to change at the plan's discretion; check with the plan for more information
MEAL DELIVERY	14 meals after inpatient hospital stay
TRANSPORTATION	24 one-way trips per year

Additional Medicare preventive services include: Ultrasound screening for abdominal aortic aneurysm, cardiovascular disease screening, diabetes screening tests, diabetes self-management training, medical nutrition therapy, glaucoma screening, smoking and tobacco use cessation counseling, HIV screening, screening and behavioral counseling interventions in primary care to reduce alcohol misuse, screening for depression, high intensity behavioral counseling to prevent STIs, intensive behavioral therapy for cardiovascular disease, intensive behavioral therapy for obesity and annual wellness visit.

Medicare Open Access PPO Appeal Process

If you have a problem with your Medicare Open Access PPO or you believe a claim has been unfairly denied, you must follow the guidelines established by your plan and Centers for Medicare and Medicaid Services (CMS). Please see page 101 for the Appeals Process.

MEDICARE OPEN ACCESS PPO ENROLLMENT AND REVIEW PROCESS

REHP Medicare-eligible members have the option of the Medicare Open Access PPO for their medical coverage. The REHP Medicare Supplemental and Major Medical (MS/MM) coverage is available to members only under the following limited circumstances:

Automatic Enrollment Exceptions – To qualify for an automatic enrollment exception, the member must verify that they meet the requirements of one of the three automatic enrollment exception categories identified below:

- Members who reside out-of-country in a region where the Medicare Open Access PPO is not offered; or
- United Mine Workers Retiree (UMW) plan members; or
- Members with Black Lung coverage

Members who meet one or more of these criteria, may **request an exception** to the normal plan enrollment of the Medicare Open Access PPO by calling the PEBTF at 1-800-522-7279 and requesting enrollment in the MS/MM plan. Members who are not satisfied with the PEBTF response to their request for exception may **file a written request for further review to the commonwealth**. The postmark date of all correspondence in this process will be used to determine timelines. The steps in the written request process are:

1. Members must file a written request for review to the PEBTF which is postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days after their telephone request is denied. Requests are to be mailed to:

REHP Reviews, PEBTF
Mailstop: RPAED, 150 S 43rd Street, Harrisburg, PA 17111

The request must include a letter and other supporting documentation explaining why you believe the PEBTF's decision should be reconsidered.

2. The PEBTF will forward the request for review to the commonwealth.
3. The commonwealth will review the request, including such other pertinent information as the member may present, and will provide a written response to the PEBTF within 60 days of receipt.
4. The PEBTF will notify the member of the commonwealth's decision, and the reasons. Within 30 days of the postmark date of the PEBTF's notification, the member may file a written request for review by the REHP Review Committee, which must be submitted in writing to the PEBTF at the address cited in #1 above.
5. The request will be submitted to the REHP Review Committee. The decision of the REHP Review Committee will be made within 60 days and will be final and binding.

The commonwealth reserves the right to modify or rescind any and all portions of this process at its discretion and without advance notice.

WHAT ARE MY RESPONSIBILITIES?

(Medicare Eligible Retirees)

Identification Cards

Medicare: Once enrolled in Medicare, the Social Security Administration will send you a Medicare identification (ID) card. This Medicare ID card will indicate the type of coverage you have selected – Hospital (Medicare Part A only), Medical (Medicare Part B only), or Hospital and Medical (Medicare Parts A & B). To avoid claim problems, you **must** notify the PEBTF and SERS as soon as you or an eligible dependent receives a new Medicare ID card.

You must enroll in both Medicare Part A and Medicare Part B when first eligible, including paying for retroactive enrollment if offered by Medicare, to be eligible to have medical and prescription drug coverage under the REHP.

Medicare Open Access PPO: You should present your Medicare Open Access PPO ID card to obtain medical services. Do not use your Medicare ID card.

Part D Prescription Drug Plan: You should present the REHP Prescription Drug Plan ID card at the pharmacy when you need prescription drugs. The pharmacy will fill your prescription and charge you the appropriate copayment plus any balance due if you elect to buy a brand name drug when a generic is available.

IMPORTANT: If you enroll in a private Part D standalone prescription drug plan or private Medicare Advantage Plan, you and your dependents REHP coverage will be terminated.

Out-of-State Claims

You may see any provider as long as they are eligible to receive Medicare payment and accept your plan anywhere in the United States and you will pay the appropriate copayment. You are also covered for urgent and emergency care anywhere in the United States. Present your Medicare Open Access PPO ID card at the time of service. You will pay a \$50 copayment for urgent care or a \$100 copayment for emergency care, which is waived if the visit leads to an inpatient admission to the hospital.

Claims Incurred Outside the Country

You are responsible for submitting claims incurred outside the country to the Medicare Open Access PPO. You should request an itemized bill and have it translated into English and into U.S. dollars. Include your name, address, Social Security number, and group number with the claim. All services will be subject to Medical Necessity review.

PRESCRIPTION DRUG PLAN

(Non-Medicare Eligible & Medicare Eligible Retirees)

Non-Medicare Eligible Members: You are enrolled in a non-Medicare Part D prescription drug plan. If you have a Medicare-eligible spouse or dependent, please refer to the information below.

Medicare Eligible Members: You are enrolled in a Medicare Part D prescription drug plan offered by the REHP. Many standard Medicare Part D programs use the term “donut hole” to describe a coverage gap where members pay the entire cost of the prescription. The REHP Medicare Part D prescription drug plan does not have a donut hole. Therefore, your benefits are similar to those offered to non-Medicare eligible members. Your non-Medicare spouse or dependent is enrolled in a non-Medicare Part D prescription drug plan.

You must continue to be enrolled in Medicare Part A and B to be covered under the Medicare Part D prescription drug plan.

Summary – Prescription Drug Plan

- Prescription drug coverage for you and your eligible dependents
- Three Tier copayment plan
- Retail and Maintenance Programs
- Medicare eligible members are enrolled in a Medicare Part D prescription drug plan

The Prescription Drug Plan gives you and your eligible dependents the opportunity to obtain your required medications at participating pharmacies throughout the United States.

If you use a pharmacy that does not participate in the pharmacy network, or you do not present your Prescription Drug Plan ID card to a Participating Pharmacy, you pay the full cost of your prescription. You must then file a claim with the prescription benefit manager in order to receive reimbursement. See “Filing a Direct Claim Form” for more information.

To find out if your pharmacy participates, call the number that appears on the back of your prescription drug ID card.

If any particular prescription drug expense that is covered under this section would also be covered under one or more other Plan Options: 1) a Member incurring such expense may obtain reimbursement for the expense under only one Plan Option; and 2) the PEBTF may, at its discretion, specify that certain types of prescription drug expenses, including without limitation infused medicines, will be covered under one or more Plan Options to the exclusion of one or more other Plan Options.

Three Tier Copayment Plan

Both the non-Medicare and Medicare prescription drug plans are generic reimbursement plans. You may obtain a brand-name drug, but if an FDA-approved generic is available, you will pay a higher copayment and the cost difference between the brand and the generic drug. In no event will you pay more than the actual cost of the drug.

Both the non-Medicare and Medicare prescription drug plan uses a three-tier system, where the prescription benefit manager maintains a list of generic and brand-name drugs called a

formulary. The formulary summary is available at www.pebtf.org. Drugs included on that list are called "preferred". Drugs not on that list are called "non-preferred." The following details the copayments under your Prescription Drug Plan.

Prescription Drug Plan – Non-Medicare Eligible Members

Prescriptions at a Network Pharmacy Up to a 30 Day Supply		Your Copayment
Tier 1: Generic drug		\$15
Tier 2: Preferred brand-name drug		\$40, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug		\$80, plus the cost difference between the brand and the generic, if one exists
CVS – Retail Maintenance & Mail Order Up to a 90 Day Supply		Your Copayment
Tier 1: Generic drug		\$22.50
Tier 2: Preferred brand-name drug		\$60, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug		\$120, plus the cost difference between the brand and the generic, if one exists
Retail Maintenance at a Rite Aid Pharmacy Up to a 90 Day Supply		Your Copayment
Tier 1: Generic drug		\$30
Tier 2: Preferred brand-name drug		\$80, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug		\$160, plus the cost difference between the brand and the generic, if one exists

Prescription Drug Plan Medicare Eligible Members

Prescriptions at a Network Pharmacy Up to a 30 Day Supply		Your Copayment
Tier 1: Generic drug		\$12
Tier 2: Preferred brand-name drug		\$30, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug		\$60, plus the cost difference between the brand and the generic, if one exists
CVS – Retail Maintenance & Mail Order Up to a 90 Day Supply		Your Copayment
Tier 1: Generic drug		\$18
Tier 2: Preferred brand-name drug		\$45, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug		\$90, plus the cost difference between the brand and the generic, if one exists
Retail Maintenance at a Preferred or Non-Preferred Network Retail Pharmacy (Medicare) Up to 90 Day Supply		Your Copayment
Tier 1: Generic drug		\$24
Tier 2: Preferred brand-name drug		\$60, plus the cost difference between the brand and the generic, if one exists
Tier 3: Non-Preferred brand-name drug		\$120, plus the cost difference between the brand and the generic, if one exists

NOTE – Medicare-eligible members enrolled in the Medicare Part D prescription drug plan: You may obtain a 90-day supply at any pharmacy that agrees to be part of the Medicare Part D prescription drug plan’s network at slightly higher copays than you pay at a CVS pharmacy or mail order. The copays are the same as what you pay at a Rite Aid pharmacy.

Retail Prescriptions – up to a 30-day supply

- Present your prescription drug ID card at the Participating Pharmacy along with the prescription to be filled
- The pharmacist will ask the person picking up the prescription to sign a log
- The pharmacist will request the copayment amount, and if necessary, the difference between the cost of the brand name drug and the cost of the generic

Except as otherwise noted, prescriptions purchased at a retail pharmacy cannot exceed a 30-day supply for short-term prescriptions.

Three Ways for Obtaining Prescriptions for up to a 90-day Supply

The Prescription Drug Plan includes three options for obtaining long-term maintenance prescriptions (up to a 90-day supply):

- Mail Order
- CVS Pharmacy
- Rite Aid Pharmacy

There are copayment differences between the two retail pharmacy maintenance feature options. See the chart on the previous page for copayment amounts.

The 90-day supply feature is appropriate if you have a chronic condition and take medication on an on-going basis. For example, this feature works well for people who use maintenance drugs for conditions such as diabetes, arthritis, asthma, ulcers, high blood pressure or heart conditions.

NOTE – Medicare-eligible members enrolled in the Medicare Part D prescription drug plan: You may obtain a 90-day supply at any pharmacy that agrees to be part of the Medicare Part D prescription drug plan's network at slightly higher copays than you pay at a CVS pharmacy or mail order. The copays are the same as what you pay at a Rite Aid pharmacy.

Specialty Medications

Specialty medications are used to treat complex conditions and usually require injection and special handling. To obtain these specialty medications, you should use the prescription benefit manager's specialty care pharmacy, CVS pharmacy or Rite Aid pharmacy. If you use a pharmacy other than the specialty care pharmacy, CVS pharmacy or Rite Aid pharmacy to purchase specialty medications, you will be responsible for the full cost of each prescription. You may then file a Direct Claim Form. The amount reimbursed to you, however, will be limited to the amount that would have been paid to the specialty care pharmacy or to Rite Aid and may result in significant out-of-pocket expenses.

The specialty care pharmacy is a mail order service, and it offers access to personalized counseling from a dedicated team of registered nurses and pharmacists to help you throughout your treatment. This personalized counseling provides you with 24-hour access to additional support and resources that are not available through traditional pharmacies.

Contact the PEBTF for information on the specialty care pharmacy.

Covered Drugs

- Federal legend drugs
- State restricted drugs
- Compound prescriptions (will not be covered if the compound includes a drug excluded by the Prescription Drug Plan)
- Insulin or other prescription injectables
- Allergy extract serums (will not be covered if the serum includes a drug excluded by the Prescription Drug Plan)
- Federal legend oral contraceptives (no copayment for non-Medicare eligible members)
- All Medicare-eligible retirees receive insulin, syringes and needles through the Prescription Drug Plan
- Genetically engineered drugs (with prior authorization)
- Shingles vaccine (Shingrix and Zostavax) – **Non-Medicare eligible members:** Immunizations are covered under your medical plan. Shingrix is covered age 50 and

older; Zostavax is covered age 60 and older. **Medicare-eligible members:** Shingles vaccines are covered according to Medicare guidelines – covered under the Prescription Drug Plan

- Infused medicine (with prior authorization)

Preventive Care Covered Medications – No Copayment for Non-Medicare Eligible Members

The following medications are covered at no cost under your prescription drug plan with a prescription from your doctor.

- Aspirin for the prevention of cardiovascular disease – adults age 50 to 59
- Aspirin to help prevent illness and death from preeclampsia in women age 12 and older after 12 weeks of pregnancy who are at high risk for the condition
- Bowel preparation medications for screening colorectal cancer for adults age 50 through 74
- Contraceptives (for females) including emergency contraceptives and over-the-counter contraceptive products (sponges, spermicides)
- Folic acid daily supplement for women only age 55 or younger who are planning to become pregnant or are able to become pregnant
- Medications for risk reduction of primary breast cancer in women age 35 and older
- Oral fluoride for preschool children older than six months to five years of age without fluoride in their water
- Tobacco cessation and nicotine replacement products – prescription drug coverage is for the generic form of Zyban or brand-name Chantix (limited to a maximum of 168-day supply)
- Statins to help prevent serious heart and blood vessel problems (cardiovascular disease) in adults age 40 to 75 who are at risk. This covers generic low to moderate intensity statins only (see section below)

Free Cholesterol-Lowering Medications*

The following cholesterol-lowering medications (generics only), known as statins, are covered free of charge under your Non-Medicare Prescription Drug Plan:

- Atorvastatin 10mg, 20mg
- Fluvastatin 20mg, 40mg
- Fluvastatin ER 80mg
- Lovastatin 10mg, 20mg, 40mg
- Pravastatin 10mg, 20mg, 40mg, 80mg
- Rosuvastatin 5mg, 10mg
- Simvastatin 5mg, 10mg, 20mg, 40mg

*Low to moderate dose statins, generics only, will be \$0 copay (no high dose or brand statins are included).

Flu Vaccine

Non-Medicare eligible members

You have two options for getting your flu shot:

1. **At your doctor's office:** Present your medical plan ID card and pay the appropriate copay.
2. **At a CVS Caremark Flu Shot network pharmacy:** For members age 9 and older – present your prescription drug ID card.

You can go to any pharmacy that participates in the CVS Caremark Flu Shot network to receive your shot. The Flu Shot network includes most chain pharmacies such as Acme, Giant, Giant Eagle, Target, Weis Markets and Rite Aid, in addition to CVS pharmacies and many independent pharmacies. Call or stop by your local pharmacy to make sure they have the flu shots in stock, and that they participate with CVS Caremark Flu Shot Program for insurance.

Simply present your CVS Caremark prescription drug ID card at the pharmacy and you and your dependents will get the flu shot at no cost. If you have filled a prescription at that pharmacy since July 2012, the pharmacy should have a record of your ID number in its system.

Other Preventive Immunizations: You may also obtain the shingles vaccine and the pneumonia vaccine at your doctor's office or at a CVS Caremark Vaccine Network pharmacy.

Coverage is provided for the shingles vaccine – Shingrix (members age 50 and older) and Zostavax (members age 60 and older). Coverage for the pneumonia vaccine (doses and ages) is recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP). You may check with your doctor to see if you meet the requirements and are eligible for this vaccine.

Medicare-Eligible Members

You are able to get your flu shot from your doctor. Some of the Medicare plans may offer other alternatives such as getting your flu shot at certain pharmacy chains. For more information, contact your medical plan by calling the number that appears on your medical ID card.

Plan Exclusions

- Blood or blood products
- Charges for the administration of a drug
- Devices and appliances
- Diagnostic agents
- Drugs dispensed in excess of Quantity Limits or lifetime supply limits unless exception has been granted
- Drugs subject to prior authorization for which such authorization has not been obtained
- Drugs subject to Step Therapy rules if these rules have not been followed
- Drugs used for athletic performance enhancement or cosmetic purposes, including but not limited to, anabolic steroids, tretinoin for aging skin and minoxidil lotion
- FDA approved drugs for use of a medical condition for which the FDA has not approved the drug (unless prior authorization is obtained)
- Fertility medications
- Immunologic agents (including RhoGAM)
- Investigational or experimental drugs (non-FDA approved indications)
- Sexual dysfunction (MSD) drugs
- Medications lawfully obtainable without a prescription (over the counter items), except those over-the-counter medications included in the Preventive Care Covered Medications list – your doctor must write a prescription for the OTC medication
- Medications for weight reduction
- Non-sedating antihistamines
- Prescription drugs administered while you are an inpatient at a facility and billed by the facility (charges for such drugs may be considered for coverage under the applicable medical plan option)

- Prescription drugs for which coverage is provided under a plan option for medical benefits
- Refill prescriptions resulting from loss, theft or damage
- Syringes, needles, lancets and test strips – excluded for non-Medicare eligible members who should obtain these through the DME benefit; lancets and test strips excluded for Medicare-eligible members who should obtain these through the Medicare Open Access PPO
- Unauthorized refills
- Any other exclusion as determined by the commonwealth

Non-Medicare Eligible Members: There is a list of formulary exclusions of medications that are not covered by the prescription drug plan without a prior authorization for medical necessity. If prior authorization is denied, you will pay the full cost of the drug. This list of formulary exclusions is modified on an annual basis by the prescription benefit manager and may be found on the PEBTF website.

Limits on Certain Drug Classes

Quantity Limitations

There are certain prescription drugs that are subject to quantity limits. The quantity limit list is posted on the PEBTF web site, www.pebtf.org/Publications.

You may find that the quantity of a medication you receive and/or the number of refills are less than you expected. This is because the pharmacists must adhere to certain federal/state regulations and/or recommendations by the manufacturer or prescription benefit manager that restrict the quantity per dispensing and/or the number of refills for a certain medication.

Step Therapy

When many different drugs are available for treating a medical condition, it is sometimes useful to follow a stepwise process for finding the best treatment for individuals. The first step is usually a simple, inexpensive treatment that is known to be safe and effective for most people. Step therapy is a type of prior authorization that requires that you try a first-line therapy before moving to a more expensive drug. The first-line therapy is the preferred therapy for most people. But, if it doesn't work or causes problems, the next step is to try second-line therapy.

You will be required to use a first-line drug before you can obtain a prescription for a second-line drug on the following classes of drugs:

- ACE's and ARB's which are used for hypertension
- COX-2 or NSAID drugs which are used for pain and arthritis.

Prior Authorization

Your Prescription Drug Plan requires prior authorization for certain medications. This requirement helps to ensure that members are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA).

For most of the drugs that appear on the prior authorization list, the process takes place at the pharmacy. If you try to obtain a drug that appears on the prior authorization list, your pharmacist will be instructed to contact the prescription benefit manager. Participating

Pharmacies then will contact your physician within 24 hours to verify diagnosis and to obtain other relevant information to make a determination of coverage.

If the request is approved, you will be notified to go to the pharmacy to obtain the medication. The approval for that specific drug will be for a period from several days up to a maximum of one year. If the request is denied, you have the right to appeal this decision to the prescription benefit manager. Please see page 100 for the Appeals Process.

The prior authorization List is on the PEBTF web site – www.pebtf.org.

Filing a Prescription Drug Direct Claim

File a prescription drug claim with the prescription benefit manager if you or a covered dependent:

- Use a pharmacy that is not part of the pharmacy network
- Do not use the prescription drug ID card when filling a prescription
- Purchase allergenic extracts from a physician
- Purchase a prescription drug from a physician

Prescription Drug Direct Claim/Coordination of Benefits Forms are available from the prescription benefit manager, the PEBTF or may be downloaded from the PEBTF website, www.pebtf.org. The prescription benefit manager will accept Direct Claim/Coordination of Benefits Forms completed in their entirety along with the receipt that must include:

- Pharmacy or physician's name and address
- Date filled
- Drug name, strength, National Drug Code (NDC)
- RX number, if applicable
- Quantity
- Days supply
- Price
- Patient's name

All Prescription Drug Direct Claim/Coordination of Benefits Forms must be postmarked within one year from the date the prescription was filled.

You will be reimbursed based on the amount a Participating (network) Pharmacy would have been paid by the Prescription Drug Plan for filling the prescription minus your copayment. In the case of an allergy extract, you will be reimbursed for the full cost of the extract itself minus your copayment amount. The balance, if any, is your responsibility and is not eligible for consideration under any medical plan.

Filing a Claim for Residents of Nursing Homes

All Retiree Members:

To obtain reimbursement for prescription drug claims incurred while you or a dependent are a resident of a nursing home whose pharmacy does not participate with the REHP Prescription Drug Plan, claims should be submitted to the prescription benefit manager using a Direct Claim/Coordination of Benefits Form.

You or your representative should notify the prescription benefit manager that the direct reimbursement is being requested because the member is a resident of a nursing home and could not use a network pharmacy. The timely filing limitation will be enforced.

The mandatory generic provision will not apply to residents of nursing homes whose pharmacies do not participate with the REHP Prescription Drug Plan. You will save money by choosing generic drugs.

Workers' Compensation Claims

Retirees who have workers' compensation claims, which resulted from commonwealth employment and are administered by the commonwealth's workers' compensation claims administrator, are required to use their prescription drug ID card provided at the time of injury or provided by the worker's compensation claims administrator to obtain medications used to treat those work-related injuries unless the Workers Compensation carrier has made other arrangements. If you do not have a worker's compensation prescription drug card, contact your claims adjuster. Retirees may continue to use their prescription ID card and present it to a Participating Pharmacy and pay the usual copayment. The commonwealth will automatically reimburse you, within 45 days, for any prescription drug copayments incurred for treatment of work-related injuries.

NOTE: Any workers' compensation claims for which a retiree has signed a Compromise and Release Agreement that includes medical claims may not be submitted for prescription or medical payment under the REHP.

COBRA COVERAGE AND SURVIVOR SPOUSE/DOMESTIC PARTNER COVERAGE (ALL RETIREES)

Summary

- If you or your dependent's health benefit coverage ends due to certain reasons, the REHP may continue your coverage for a limited period of time
- Federal law also allows you to continue coverage at your own expense under certain circumstances under the Federal law commonly known as COBRA

Continued Coverage as Provided by the REHP

In certain situations, medical coverage for you and your eligible dependents may be extended. If coverage would end while a member is in the hospital, coverage continues until the member is discharged from the facility or benefits are exhausted, whichever occurs first.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed below. You can also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

There may be other coverage options for you and your family. You also may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Survivor Spouse/Domestic Partner Coverage

Act 183 allows the survivor spouse (only) of a SERS retiree to continue coverage under the REHP on a direct pay basis. The REHP extends this benefit to domestic partners through December 31, 2020 (must have been enrolled as a domestic partner as of December 31, 2019). If a survivor spouse/domestic partner is not Medicare eligible, he or she may elect the options available based on the retiree's date of retirement. Survivor spouse/domestic partner coverage is available for spouses/domestic partners of PSERS, or other approved retirement system retirees participating in the REHP.

If a survivor spouse/domestic partner is eligible for Medicare, the survivor spouse/domestic partner must elect Medicare Parts A and B. He or she also may enroll in the Medicare Open Access PPO and the Prescription Drug Plan.

A survivor spouse/domestic partner must elect the coverage type and plan in place at the time of the retiree's death. A survivor spouse/domestic partner may change plans during the Open Enrollment time period.

If the deceased annuitant elected a survivor retirement annuity, the cost of the health coverage will be deducted each month from the survivor's annuity. If the monthly cost of the health coverage is greater than the monthly survivor annuity, the PEBTF will bill the survivor the full amount of the premium.

Non-Medicare Eligible Members

If the survivor spouse/domestic partner returns the form to SERS electing coverage within 30 days of receipt, coverage will be retroactive to the date their coverage ended. The cost of this retroactive coverage will be the survivor spouse's/domestic partner's responsibility. However, if the survivor spouse/domestic partner pays the premiums for retroactive coverage, then any claims he or she incurred after their coverage ended can be considered for payment. If the enrollment application is not received by SERS within 30 days, then coverage will be effective the first of the month following the postmark date. In this instance, coverage will not be retroactive and any claims that were incurred will not be considered for payment by the REHP.

Medicare Eligible Members

Under CMS Medicare COBRA regulations, Medicare eligible survivor spouses/domestic partners must be given a 21 day notice from the date that the PEBTF receives notification of the qualifying event (death) prior to termination of REHP coverage. If the notification date does not allow the 21 day notice before the end of the month, the REHP coverage will be extended an additional month. For example, if the PEBTF is notified on November 15th of the death and the spouse/domestic partner is in the Medicare Open Access PPO; the spouse/domestic partner would be covered until December 31st.

The Medicare eligible spouse/domestic partner then would be returned to Traditional Medicare Parts A and B effective the 1st day of the next month and will not receive REHP medical or prescription drug coverage. If survivor spouse/domestic partner coverage is elected, the effective date in the Medicare Open Access PPO would be the 1st of the month following the receipt of the election notice. Any claims incurred between the end the month and the 1st of the month following election of survivor spouse/domestic partner coverage will be processed under the Medicare Supplemental plan.

On rare occasions, a spouse/domestic partner dies so soon after the death of a retiree that there is insufficient time for the spouse/domestic partner to elect continued coverage under the REHP. The REHP allows for retroactive election of survivor spouse/domestic partner coverage by the executor of a deceased spouse's/domestic partner's estate, if a survivor spouse/domestic partner dies within 60 days of the death of a retiree. The executor shall be limited to electing coverage under the health plan in which the survivor spouse/domestic partner was enrolled prior to the date of his or her death. If a survivor spouse/domestic partner dies later than 60 days after the death of the retiree, the PEBTF shall assume that either the spouse/domestic partner or their authorized representative had sufficient time to elect either COBRA or survivor spouse/domestic partner coverage. In the latter instance, the executor of the spouse's/domestic partner's estate shall not be allowed to retroactively elect survivor spouse/domestic partner or COBRA coverage.

NOTE: If the survivor spouse/domestic partner is also a commonwealth retiree and REHP eligible, they may elect to return to their own REHP coverage instead of electing the survivor spouse/domestic partner benefits. If this is the case, the survivor spouse/domestic partner should contact SERS for enrollment in their own retiree coverage. If the survivor spouse/domestic partner is covered under PSERS, or other approved retirement system, the survivor spouse/domestic partner should contact the PEBTF.

Coverage under the survivor spouse/domestic partner benefit also is available to those spouses/domestic partners of active or former commonwealth employees that could have retired with REHP coverage the day prior to their death. The SERS office will send a notice to the survivor spouse/domestic partner, if appropriate.

NOTE: Please see page 13 for information on your REHP medical and prescription drug options. **If you enroll in a private Part D prescription drug standalone plan or private Medicare Advantage Plan, you and your dependents REHP coverage will be terminated.**

COBRA Continuation Coverage

As provided by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), your eligible dependents have the right to continue benefits under the REHP if coverage ends for certain specified reasons which are referred to as "qualifying events:"

- Your death; in the event of your death, your dependents should report the death to SERS. SERS will report it automatically to the PEBTF
- Your divorce/termination of domestic partnership or legal separation (in states that recognize legal separation) – SERS must be notified within 60 days of the date of divorce/termination of domestic partnership in order to issue a COBRA Election Notice
- Your dependent child no longer meets the eligibility requirements for coverage

NOTE: If you voluntarily drop (disenroll) a dependent from coverage as permitted by the REHP rules, who would otherwise be an eligible dependent if not disenrolled, this is not a COBRA qualifying event. Likewise, if your or your dependent's coverage is suspended by the REHP for failure to repay amounts owed, or for failure to cooperate with respect to subrogation or coordination of benefits, such suspension is not a COBRA qualifying event.

NOTE 2: Federal law (COBRA) includes legal separation as a qualifying event. However, Pennsylvania law does not recognize or provide for a legal separation.

NOTE 3: COBRA coverage for domestic partners will only be provided through December 31, 2020.

Notices – Important

You or another qualified beneficiary in your family has the responsibility to inform SERS of a divorce/termination of domestic partnership, legal separation or child's loss of dependent status under the plan. This information must be provided within 60 days of the date of the qualifying event. Otherwise, you (or your family member) will not be permitted to continue coverage under COBRA. If coverage is lost due to a retiree's death, your dependents should report the death to SERS. SERS will report it automatically to the PEBTF.

When the PEBTF becomes aware of a qualifying event, the PEBTF will notify the affected dependent that he or she has the right to choose continuation coverage. That notice will include more information about rights under COBRA. As discussed above, the former member will have 60 days to elect COBRA coverage. If he or she fails to elect COBRA, the PEBTF coverage will terminate under the ordinary terms of the plan. You should notify the PEBTF or SERS of any changes in your address or other changes that may affect how COBRA information is provided to you.

Support Orders

Either the retiree member or the dependent spouse/domestic partner member may elect COBRA coverage for the dependent spouse/domestic partner member. It should be noted that a court spousal support order which directs that a retiree member provide medical coverage for his/her spouse/domestic partner does not, and cannot, require that the REHP do anything other than comply with the terms of the benefit plan, including the plan's provisions and procedures for continuation coverage under COBRA. Therefore, the retiree member or spouse/domestic partner member must duly elect, and timely pay for, COBRA coverage in accord with the plan's COBRA requirements in order to fulfill the retiree member's obligation under the court order. Such a court order for spousal support relates only to the retiree member's obligation, as the PEBTF, the REHP, and the commonwealth are not parties under the court's jurisdiction in such a legal action.

Cost of Continued Coverage

Continued coverage is available to your dependent at your or your eligible dependent's expense. The cost to you or your dependents for this continued coverage will not exceed 102% of the REHP's cost, as determined by the commonwealth. However, in the case of a disabled individual whose 18-month continued coverage is extended to 29 months, the cost can be up to 150% of the REHP's cost during this 11-month period.

You also will receive a notice from your health plan indicating that your coverage has been terminated.

Applying for Continued Coverage

You, your spouse/domestic partner or former dependent child is obligated to notify SERS, in writing, within 60 days of a divorce/termination of domestic partnership or a dependent child losing dependent status in order for the COBRA notice to be sent timely. If the retiree, spouse/domestic partner or former dependent child does not notify SERS within 60 days of a divorce/termination of domestic partnership or loss of dependent status, then the spouse/domestic partner or former dependent child will not be eligible to elect COBRA continuation coverage. Failure to notify the PEBTF of these events within the 60 day time limit will cause COBRA coverage to be unavailable.

If the PEBTF is notified within the 60 day time limit of the qualifying event, the PEBTF shall, within 14 days, send a COBRA election notice to the affected dependents, by First Class Mail. The former member will have 60 days to elect COBRA continuation coverage. They must elect and send the Election Form to the PEBTF on or before the 60th day from such notification date. **If the Election Form is not mailed (postmarked) before or by the 60th day, the former member will not receive another opportunity to elect COBRA coverage.**

If they elect continued coverage within 60 days of losing coverage or the date they are notified, whichever is later, their coverage will be effective as of the date they became ineligible. The coverage is reinstated retroactive to the qualifying event. However, expenses incurred by the member who lost coverage must be resubmitted for payment.

If you or your dependent has informed the PEBTF of a qualifying event within the 60 day time limit, but are determined to be ineligible for COBRA coverage, the PEBTF will send you a notice of COBRA unavailability explaining the reason.

PLEASE NOTE: The retiree will be responsible for any claims incurred by the retiree's former spouse/domestic partner or dependent child after eligibility for REHP coverage is lost, unless SERS is notified within 30 days of the effective date of the divorce. SERS has the responsibility to notify the PEBTF of the retiree's death within 30 days from the date SERS is notified.

Paying for COBRA Coverage

Within 45 days of the election of COBRA, you must pay an initial premium which will be billed by the PEBTF. This premium includes the period of coverage from the date of your qualifying event to the date of the election notice, and any regular monthly premium that becomes due between the election and the end of the 45-day period. Thereafter, premiums must be paid monthly and must be postmarked to the PEBTF on or before the due date or COBRA coverage will be terminated. This time limit will be strictly enforced. If your premium is not postmarked timely, you will receive a "reminder notice" which identifies the grace period – the end of the month for which the premium is due. However, if payment is not postmarked by the last day of the month, coverage will be terminated and you will receive a "termination notice" within two weeks. Initial COBRA notices are sent to the retiree member's last known address according to PEBTF records. Notices to COBRA members are sent to the address specified on the COBRA Election Form. It is the responsibility of the COBRA member to notify the PEBTF, in writing, of any address change.

Effect of Waiving COBRA Coverage

If coverage is waived or the former member fails to timely respond to the COBRA Election Notice, COBRA may not be elected after the 60-day election period. In addition, if the dependent experiences a gap in coverage as a result of a waiver of COBRA, the waiver of COBRA may affect a dependent's Certificate of Coverage (which protects a member's right not to be affected by pre-existing medical condition requirements when obtaining new medical insurance, e.g., under a new employer's plan of benefits).

Length of Continued Coverage

COBRA continuation coverage will end on the earliest of the following dates:

- At the end of 18 months from the date COBRA coverage began if the qualifying event is because your disability retirement is denied after re-examination
- At the end of 36 months from the date COBRA coverage began for your dependent if the qualifying event is your death, divorce/termination of domestic partnership or separation, your child's loss of dependent status, or the dependent's entitlement to Medicare
- Failure to pay the required monthly premium, other than the first premium, within 30 days of the due date. Coverage will be canceled retroactive to the paid thru date. The PEBTF will not issue a pro-rata refund for COBRA premiums.
- Your eligible dependent becomes, after the date of the COBRA election, entitled to Medicare
- Your eligible dependent becomes, after the date of the COBRA election, covered under another group health plan (as an employee or otherwise)
- The REHP terminates all of its health care plans
- The end of the period for which the premium was paid for the COBRA benefit

If COBRA coverage is terminated prior to the end of scheduled period of coverage, the PEBTF will send the COBRA member a notice of early termination of COBRA explaining (1) the reason for termination, (2) the effective date and (3) an explanation of any rights the COBRA member may have to elect alternative coverage.

Special Disability Rules

An 18-month continuation of COBRA coverage may be extended to 29 months if:

- Your dependents are determined by the Social Security Administration to be totally disabled and the disability occurred within the first 60 days of COBRA coverage provided that:
 1. Your dependent notifies the PEBTF of the disability determination before the end of the 18-month period, and
 2. The disability continues throughout the continuation period
- The special rules apply to the disabled individual and to other dependents

In order to qualify for the additional 11 months of extended coverage, your disabled dependents must notify the PEBTF within 60 days of being classified as totally disabled under Social Security. Likewise, if Social Security determines that a dependent is no longer totally disabled, you must notify the PEBTF within 30 days.

Extension of COBRA Due to a Second Qualifying Event

If a second qualifying event occurs before the end of the 18 months of COBRA coverage due to termination of employment or reduction in work hours, you may be entitled to an additional 18 months of COBRA coverage for a total of up to 36 months.

A second qualifying event includes:

- Death of a COBRA Employee Member
- Divorce/termination of domestic partnership
- Change in Dependent status
- Medicare entitlement of Employee Member

You must notify the PEBTF of a second qualifying event within 60 days.

COBRA Open Enrollment

During the Open Enrollment period, the COBRA member may change plan options. As a COBRA participant, you may enroll in any REHP approved plan for which you are eligible (based on retiree's date of retirement) which offers service in your county of residence.

Further Information

The rules that apply under COBRA may change from time to time. If you have any questions about COBRA, please write or call the PEBTF or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Office are available through EBSA's website at www.dol.gov/ebsa.

Additional Information

(All Retirees)

Appeals – Expedited Appeal Process For Non-Medicare Retirees Only

The REHP offers an expedited appeal process. An expedited procedure for conducting such review is available, as follows:

The commonwealth recognizes that there may be appeal cases where expedited review is medically necessary in order to secure prompt and appropriate medical treatment. Where the commonwealth is authorized to review appeals, the Executive Director of the PEBTF, in consultation with such PEBTF staff as the Executive Director deems appropriate may, in his or her sole discretion, submit an appeal for expedited review to the commonwealth, due to medical necessity. The commonwealth will review the appeal in accordance with established procedures.

Appeals – Right to Appeal Prior Authorization Determinations For Non-Medicare Retirees Only

The claims payor acting under the authority of the PEBTF, and not the PEBTF itself, shall be responsible for reviewing and making all determinations, on initial request and every level of appeal, for any authorization or approval that you are required to obtain under the terms of this plan prior to the provision of any service or product. Such reviews and determinations shall be made in accordance with the procedures of the claims payor. The commonwealth shall not review any of these prior authorizations or approval decisions, except, to the extent that:

1. The claims payor has issued the final determination that it will render under its procedures with respect to a request by you for prior authorization; and
2. You are not satisfied with such determination; and
3. The denial is not based on any decision as to the Medical Necessity or experimental or investigational nature of a service or product or on any other clinical or medical judgment; you may appeal such decision to the commonwealth and the commonwealth shall review such appeal in accordance with the procedures set forth in the appeals section of this Handbook. To the extent a Claim's Payor's prior authorization or appeal determination is not or cannot be appealed, the determination shall be final and binding.

The provisions of this section shall be subject to any rights that you have under applicable law to review a plan determination by a governmental or other entity, other than the PEBTF or a claims payor.

Appeal Process – Eligibility Denied

Your written appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) to the PEBTF within 180 days of the denial of eligibility. A failure to appeal within this 180 day period will result in an automatic denial of your appeal. Your letter should include information as to why you believe that the eligibility rules were not correctly applied. Address your letter to the PEBTF, Mailstop: RPAED, 150 S. 43rd Street, Harrisburg, PA 17111.

The commonwealth will review your appeal, including such other pertinent information as you may present and the PEBTF will notify you of the commonwealth's decision, and the reasons therefore.

All appeal decisions rendered by the commonwealth are final.

Appeal Process – All Non-Medicare Health Plan Options (PPO & HMO Options) & Mental Health and Substance Abuse Program (MHSAP)

If your claim for benefits under the health plan is denied, the claims payor will advise you in writing of the denial, the reason(s) for it, and the steps you can take to appeal the denial. You must follow the claims payor's procedures for appealing a denied claim.

Your written request for appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class) to the claims payor within 180 days after you receive notice of the denial (which may take the form of an Explanation of Benefits). You (or your authorized representative) can submit issues and comments in writing. The claims payor will advise you of its decision on appeal, including if you have the right (if your appeal is denied) to a second-level appeal to the claims payor. The claims payor will advise you of the specific reason(s) for its decision, including references to the provisions of the plan (or the claims payor's policies and procedures) on which it is based. You have the final right of appeal to the Commonwealth of Pennsylvania's Office of Administration, as set forth below in the paragraph entitled "Final Appeal Process."

Appeal Process – Prescription Drug Plan Prior Authorization

Your Prescription Drug Plan requires prior authorization for certain medications. This requirement helps to ensure that members are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA). For most of the drugs that appear on the prior authorization list, the process takes place at the pharmacy. If you try to obtain a drug that appears on the prior authorization list, your pharmacist will be instructed to contact the prescription benefit manager. Participating pharmacies will then contact your physician within 24 hours to verify the diagnosis and to obtain other relevant information to make a determination of coverage.

If the request is approved, you will be notified to go to the pharmacy to obtain the medication. The approval for that specific drug will be for a period from several days up to a maximum of one year. If the request is denied, you have the right to appeal this decision to the prescription benefit manager.

Final Appeal Process

If you are not satisfied with the claims payor's decision on appeal, you have the right to appeal to the Commonwealth of Pennsylvania's Office of Administration. All final appeals must include copies of the claims payor's final denial(s), along with a letter and other supporting documentation explaining why you believe the claims payor's decision should be

reconsidered. Mail your appeal to the PEBTF, Mailstop: RPAED, 150 S. 43rd Street, Harrisburg, PA 17111 postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the claims payor's final decision. The PEBTF will then forward the appeal to the Commonwealth's Office of Administration for review. The Commonwealth's Office of Administration will review your appeal, including such other pertinent information as you may present and the PEBTF will notify you of the Commonwealth's Office of Administration's decision, and the reasons therefore.

All decisions rendered by the Commonwealth of Pennsylvania's Office of Administration are final and binding.

If you fail to file an appeal, as set forth above, then you shall be deemed to have forfeited your right to commence legal action. You may not commence legal action until after you have exhausted all claim and appeal rights and received a final decision from the Commonwealth's Office of Administration.

In the event you are awarded an amount in benefits that were denied under the Plan when you failed to exhaust your claim and appeals rights, you will forfeit the right to that amount of benefits with respect to future claims.

The commonwealth will not consider appeals of claim denials based on medical necessity or experimental or investigative nature of a service or product or on any other clinical or medical judgment. The claims payor's decision on such claims is final and binding.

Appeal Process – Medicare Open Access PPO

If you have a problem with your Medicare Open Access PPO or you believe a claim has been unfairly denied, you must follow the guidelines established by the Medicare Open Access PPO and Centers for Medicare and Medicaid Services (CMS) and published in your Evidence of Coverage (EOC). There also is a State Health Insurance Advisory Program (SHIAP) which you can call for assistance with Medicare bills including payment denials or appeals. In Pennsylvania, SHIAP can be reached at 1-800-783-7067. Claims denied by the Medicare Open Access PPO may not be appealed to the Commonwealth of Pennsylvania's Office of Administration. The commonwealth does not have the authority to change the Medicare Open Access PPO's claim decision.

Section 1557 of the Affordable Care Act – Grievance Procedures

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services prohibit discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. The PEBTF has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557. The PEBTF has also designated a Civil Rights Coordinator to coordinate efforts to comply with Section 1557. The text of Section 1557 and its implementing regulations may be examined in the office of the Civil Rights Coordinator.

At the time these grievance procedures are established, you may contact the Civil Rights Coordinator at PEBTF, Mailstop: CRAC, 150 S. 43rd Street, Harrisburg, PA 17111, [717-565-7200], [717-307-3372], [civilrightscoordinator@pebtf.org].

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure.

It is against the law for the PEBTF to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Civil Rights Coordinator within 90 days of the date of the alleged discriminatory action or, if it is not reasonable to expect the individual filing the grievance to be aware of such action when it occurs, the date of the first notice or other communication of the action to the individual.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Civil Rights Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough and take into account all of the evidence relevant to the complaint submitted by the individual filing the grievance. The Civil Rights Coordinator will maintain the files and records of the PEBTF relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Civil Rights Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 90 days after the Civil Rights Coordinator receives the grievance, including a notice to the complainant of the right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201.

Additional information about filing a civil rights complaint, including complaint forms, may be accessed through: <https://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

The PEBTF will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Civil Rights Coordinator will be responsible for such arrangements.

Benefits From Other Plans (Subrogation and Third Party/ Reimbursement)

If you or any of your enrolled dependents receive benefits under the REHP for injuries caused by the negligence of someone else, the PEBTF has the right to seek from the responsible party repayment in full for such benefits or to seek reimbursement from you for the full amount of benefits paid to you or your dependent, or on your or your dependent's behalf. The PEBTF has the right to recover the full 100% of all benefits paid to you or on your behalf from any third party who may have been responsible, in whole or in part, for the accident or condition which caused such benefits to be paid by the REHP. The "make whole" doctrine shall be inapplicable and shall not preclude such full recovery.

This right of subrogation/reimbursement may be exercised by the PEBTF without regard to whether you have recovered or received damages or reimbursement of any kind, in whole or in part, from any such third party. This right of first recovery applies regardless of how the damages or reimbursement is characterized (economic damages, pain and suffering, etc.) or whether the recovery is due to a court award or a formal or informal settlement. In this respect the REHP is entitled to a right of first recovery for 100% of the benefits which it paid to you or your dependents or on your or their behalf. This obligation includes benefits paid to, or on behalf of, minor children. The PEBTF pays such benefits on the condition that it will be reimbursed by you, or the guardian of a minor child, to the full extent of the benefits which it has paid.

As a condition of continued eligibility for benefits under the REHP, if you or your eligible dependents are involved in a matter in which the REHP is exercising its subrogation/reimbursement rights, you and they and anyone acting on your behalf, including an attorney, must cooperate fully and entirely to enable the PEBTF to pursue and exercise its full 100% subrogation/reimbursement rights. In addition, by accepting benefits under the REHP, you accept that the REHP has an equitable lien against any amounts from a third party, to the extent that benefits have been paid or are payable under the REHP.

This cooperation requires you (or your dependents, if applicable) to:

- a. Notify the PEBTF, in writing, postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the date you file a claim or complaint or otherwise commence litigation, arbitration or any other legal or administrative proceedings involving or referring to an expense or loss that has been or will be submitted to the PEBTF for payment. This responsibility arises whether the expense or loss is from an accident, malpractice claim or any other source. The notice to the PEBTF must include a copy of the claim or complaint;
- b. Notify the PEBTF, in writing, postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the entry of any judgment, award or decision that involves or refers to any expense or loss that has been paid by or has been or will be submitted to the PEBTF for payment. This applies whether or not the PEBTF or the commonwealth are referenced in such judgment, award or decision; and
- c. Notify the PEBTF, in writing postmarked or actually received (if sent by other than U.S. Mail First Class) within 30 days of the date a settlement offer is made or settlement discussions commence with respect to any claim (filed or not filed) relating to an expense or loss that has been paid by the PEBTF. No such settlement may be entered into with a third party without the PEBTF's prior written consent.

Failure to cooperate fully will result in disqualification from all REHP benefits for a period of time as determined by the commonwealth.

The PEBTF and/or the commonwealth may commence or intervene in any litigation, arbitration or other proceeding in order to assert its subrogation/reimbursement rights. You and your dependents, if applicable, may not oppose such participation and will assist the PEBTF in all matters relating to its subrogation/reimbursement rights, including authorizing the PEBTF, at its request, to assert a claim against, compromise or settle a claim in your name, on your behalf.

If the PEBTF takes legal action against you for failure to reimburse the PEBTF, you may be liable for all costs of collection, including reasonable attorney's fees, in such amounts as the court may allow.

To the extent required by law, this right of subrogation/reimbursement **does not apply** to any payments the PEBTF makes as a result of injuries to you or your dependents sustained in a motor vehicle accident that occurred in Pennsylvania (exception is for members enrolled in an HMO). The applicability of the PEBTF's subrogation/reimbursement rights when you or your dependents sustain an injury in an automobile accident in another state or foreign country will depend on laws of the other state or country in which the automobile accident occurred.

If the PEBTF makes a demand for reimbursement of benefits paid and you do not reimburse or repay the money, or otherwise cooperate with the PEBTF in its recoupment of monies owed, you and your dependents will be ineligible for all future benefits until the money is repaid in full, or until you make the first payment under a repayment plan agreed to between you and the PEBTF.

If you agree to a repayment plan, so that coverage is reinstated, and then fail to make any subsequent repayments when due, you and your dependents will again be ineligible for all future benefits until the money is repaid in full, and for six months thereafter.

You have the right to appeal the PEBTF's demand that you reimburse amounts paid by the PEBTF in a subrogation/reimbursement situation. To do so, your written appeal must be postmarked or actually received (if sent by other than U.S. Mail First Class within 180 days of the date of the notice or demand to you. If you file an appeal, the suspension of your and your dependents coverage will be stayed pending resolution of the appeal. The appeal will be considered by the commonwealth and you will be advised in writing of their decision.

All decisions rendered by the Commonwealth of Pennsylvania's Office of Administration are final and binding.

If you fail to file an appeal, as set forth above, then you shall be deemed to have forfeited your right to commence legal action. You may not commence legal action until after you have exhausted all claim and appeal rights and received a final decision from the Commonwealth's Office of Administration.

NOTE: A suspension of benefits as described above is not a qualifying event for self-pay continuation coverage under COBRA.

Coordination of Benefits

The PEBTF coordinates benefits with other group insurance plans under which you may be covered. For instance, your spouse/domestic partner may be covered under his or her own

medical plan. This provision is for the purpose of preventing duplicate payments for any given service under two or more plans.

- Benefits coordinated with other plans include medical, prescription drug and mental health and substance abuse services
- You cannot receive duplicate payment for the same service
- Other coverage must be reported any time there is a change in such coverage.

Example: You are not allowed to receive more than one payment for the same services. If your spouse/domestic partner is employed by a non-commonwealth employer, he or she may be covered under his or her own employer's plan as an employee and under the REHP as a dependent. To prevent duplicate payments for any given service under two or more plans, the PEBTF coordinates benefits with other group insurance plans under which you or your dependents may be covered.

When filing claims for medical or prescription drug services, you are required to indicate and identify any other insurance or group health plan(s) in which you or a dependent participates. You may be entitled to be paid up to 100% of the reasonable expenses under the combined plans. In coordinating benefits, one plan, called the primary plan, pays first. The secondary plan adjusts its benefits so that the total amount available will not exceed allowable expenses. Failure to disclose other coverage or to follow the compliance provisions of either the primary or secondary plan shall disqualify a member for coverage under this section.

The following rules are used to determine the order that benefits are paid:

The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expenses for the claim. In no event shall this plan pay more than it would have paid had it been primary.

A plan for purposes of this Section is any of the following that provides benefits or services for health care or treatment: Group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law. A plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

A plan without a coordination of benefits provision is the primary plan. If all plans have coordination of benefits provisions, the following rules shall apply in order until a determination as to which plan is primary is made:

1. **Non-dependent or dependent.** The plan that covers the person other than as a dependent is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and

primary to the plan covering the person as other than a dependent (e.g., a retired employee) then the order of benefits between the two plans is reversed so that the plan covering the person as an employee (member, policyholder, subscriber or retiree) is the secondary plan and the other plan is the primary plan.

2. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married
 - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent;
 - The plan covering the spouse of the custodial parent;
 - The plan covering the non-custodial parent; and then
 - The plan covering the spouse of the non-custodial parent.
 - c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subparagraphs (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
1. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active

employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule set forth in Subsection (a)(1) above can determine the order of benefits. The rule also does not apply if the retiree is covered under the Retired Employees Health Program ("REHP") or the Retired Pennsylvania State Police Program ("RPSPP") in which event the REHP or RPSPP shall be primary and the PEBTF shall be secondary.

2. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan that covers the person as an employee, member, subscriber or retiree or that covers the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule set forth in Subsection (a)(1) above can determine the order of benefits.
3. **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on Benefits: When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Right to Receive and Release Information: Certain facts about health care coverage and services are needed to apply the rules set forth in this Section and to determine benefits payable under this plan and other plans. The PEBTF may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the member claiming benefits. The PEBTF need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the PEBTF any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: A payment made under another plan may include an amount that should have been paid under this plan. If it does, the PEBTF may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The PEBTF will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery: If the amount of the payments made by the PEBTF is more than it should have paid under this Section, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

When the REHP is primary for coordination of benefits, and you and your dependents have other prescription drug coverage, fill your prescription through the REHP Prescription Drug Plan. When another prescription drug plan is primary for you and your dependents, submit balances to the REHP Prescription Drug Plan with a Direct Claim/Coordination of Benefits Form along with a copy of your pharmacy receipt and the primary plan’s Explanation of Benefits.

Medicare

If you or a dependent become covered under Medicare, contact SERS or the PEBTF to let them know the date Medicare begins.

Because it may result in a possible exception to the above rule, you must notify the PEBTF if you or one of your eligible dependents are receiving Medicare before age 65, for instance because of End Stage Renal Disease (ESRD) or other disability.

Felony Claims

If you or your dependents sustain injuries during the commission by you or them of a felony, the claims resulting from those injuries are excluded from coverage. If you or your dependents are acquitted of the felony charge, payment for medical expenses will be provided on a retroactive basis.

Information about Help in Paying for Your Health Insurance Coverage

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Please note that most children of Commonwealth of Pennsylvania employees are not eligible for CHIP. Children of commonwealth retirees who are eligible for health insurance through the Retired Employees Health Program (REHP) are not eligible for the Children's Health Insurance Program (CHIP) administered by the Pennsylvania Insurance Department's Office of CHIP.

Commonwealth retirees who have children who are **eligible** for REHP coverage and are currently enrolled in CHIP should immediately contact the State Employees' Retirement System (SERS) at 1-800-633-5461 to enroll their children in the REHP, then immediately contact their CHIP insurer to end CHIP coverage.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

Pennsylvania offers an assistance program only for Medical Assistance (Medicaid). For a list of the other states' assistance information, please review the information below.

PENNSYLVANIA – Medical Assistance (Medicaid) Premium Assistance
www.dhs.pa.gov 1-800-644-7730

ALABAMA – Medicaid		FLORIDA – Medicaid	
Website: http://myalhipp.com/ Phone: 1-855-692-5447		Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268	
ALASKA – Medicaid		GEORGIA – Medicaid	
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx		Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	
ARKANSAS – Medicaid		INDIANA – Medicaid	
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)		Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)		IOWA – Medicaid	
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711		Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	
KANSAS – Medicaid		NEW HAMPSHIRE – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512		Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999	
KENTUCKY – Medicaid		NEW JERSEY – Medicaid and CHIP	
Website: https://chfs.ky.gov Phone: 1-800-635-2570		Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	

<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462</p>
<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178</p>	<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>

<p>SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p>WASHINGTON – Medicaid</p> <p>Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473</p>
<p>TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p>WEST VIRGINIA – Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p>UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>	<p>WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p>
<p>VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p>WYOMING – Medicaid</p> <p>Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p>
<p>VIRGINIA – Medicaid and CHIP</p>	
<p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Admin.
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send

comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebesa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137

Motor Vehicle Insurance

If you or one of your dependents are injured as a result of a motor vehicle accident, you should contact your Motor Vehicle Insurance carrier for information regarding submission of a claim for medical benefits.

Medical benefits payable under your Motor Vehicle Insurance policy, including self-insurance, will not be paid by the REHP. A letter from the insurance company noting that benefits have been exhausted must accompany claims for any additional charges.

Within the Commonwealth of Pennsylvania, bills for medical services required as a result of a motor vehicle accident may not be billed at a rate greater than 100% of the Medicare Allowance. If you are billed an amount in excess of the Medicare Allowance, you should contact your Motor Vehicle Insurance company.

If you or one of your dependents fail to obtain primary automobile insurance as required by Pennsylvania law, the first \$5,000 of claims resulting from an automobile accident is excluded from coverage. The reduction in plan benefits shall also apply to the retiree's dependents, whether or not such dependents are legally permitted to drive. However, if the dependent of a retiree has automobile insurance coverage that meets the requirements of applicable law, independent of any automobile insurance coverage that the retiree has or has not obtained, the benefits available under the plan shall be coordinated with the dependent's automobile insurance coverage in accordance with other applicable plan provisions.

National Medical Support Notice (NMSN)

A National Medical Support Notice (NMSN) is a medical child support order transmitted by the state child support enforcement agency which is legally empowered to secure medical coverage for children under their non-custodial parent's group health plans. It is a standardized medical child support order used by the state child enforcement agencies to enforce medical child support obligations of non-custodial parents who are required to provide health care coverage through any employment related group health plan pursuant to a child support order.

A NMSN may be based on a court order (of this or another state) or an order of the state agency itself. A NMSN requires that the PEBTF immediately enroll the children, if eligible and if the NMSN meets the requirements of a qualified medical support order (and also to enroll the retiree member/non-custodial parent, if not already enrolled). The NMSN, like other qualified medical support orders, may not order the REHP to provide any benefits which are not a part of the plan of benefits.

Nondiscrimination Notice

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PEBTF, Mailstop: CRAC, 150 S. 43rd Street, Harrisburg, PA 17111, 1-800-522-7279, TTY number—711, Fax: 717-307-3372, Email: CivilRightsCoordinator@pebtf.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-522-7279 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-522-7279 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-522-7279 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-522-7279 (TTY: 711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-522-7279 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-522-7279 (TTY: 711). 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-522-7279 (TTY: 711).

(رقم 1-800-522-7279 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-522-7279 (TTY: 711). هاتف الصم والبكم: 1-800-522-7279)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-522-7279 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-522-7279 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-522-7279 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-522-7279 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-522-7279 (TTY: 711)..

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-522-7279 (TTY: 711).

Qualified Medical Child Support Orders (QMCSOs)

Divorce/termination of domestic partner situations often require the non-custodial parent to continue to provide health insurance coverage for their dependent children. The PEBTF also must house the address of the custodial parent on its system so that the custodial parent receives important health care information relating to the child. To protect the privacy of the custodial parent, the address of the custodial parent is **never** disclosed to the non-custodial parent who is the REHP member.

A Qualified Medical Child Support Order (QMCSO) is a medical child support which creates or recognizes an alternate recipient's right to receive benefits for which a member is eligible.

To define the above terms:

A **Medical Child Support Order** is a court judgment, decree or order, including that of an administrative agency authorized to issue a child support order under state law including

approval of settlement agreement, which provides for child support under a group health plan or provides for health coverage to such a child under state domestic relations law, including a community property law and related to benefits under this plan.

An **alternate recipient** is any child of a participant who is recognized under a Medical Child Support Order as having a right to enroll under a group health plan.

To be qualified, a Medical Child Support Order must clearly:

- Specify the name and last known mailing address of the member and the name and mailing address of each alternate recipient covered by the order
- Include a reasonable description of the type of coverage to be provided or the manner in which the coverage is to be determined
- Specify each period of time to which the order applies
- Specify each plan to which the order applies

A Medical Child Support Order cannot require the coverage of an individual who is not otherwise eligible as a dependent under the terms of the plan.

The PEBTF will determine, within a reasonable period of time, whether a Medical Child Support Order is qualified, and if qualified, it will proceed to administer benefits in accordance with the applicable terms of each order and the plan of benefits.

No Assignment of Benefits

No benefits payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge (collectively "Assignment") by any person, and any attempt to effect such an Assignment by a Member or any other person shall be void. The REHP has no obligation to accept any direction from any Member to make payment to any person, and any payment of benefits under the Plan that is made directly to a Provider or its agent or representative shall be made as a convenience to the Retiree Member or Dependent and will not constitute an Assignment. All benefits under the Plan shall be exempt, to the extent permitted by law, from the claims of creditors and from all orders, garnishments, executions, or other legal process or proceedings.

Notice of Creditable Coverage

Coverage under the REHP Prescription Drug Plan is considered to be "creditable coverage" for purposes of meeting the requirements specified under Medicare Part D. The Notice is available by contacting the PEBTF. Medicare-eligible members enrolled in the Medicare Part D plan offered by the REHP will not receive the Notice of Creditable Coverage

PEBTF Compliance Plan

The PEBTF has a Compliance Plan. The purpose of the Compliance Plan is to educate the PEBTF's employees, agents and staff with respect to the laws, rules and policies that govern the operation of, and their responsibilities to the PEBTF. Members may request a copy of the Compliance Plan.

Privacy of Protected Health Information

The REHP and the PEBTF adhere to the medical privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable state law, and have entered into agreements with the claims payors and other professional advisors committing

them to matching the confidentiality of personal health information as required by HIPAA. The REHP and the PEBTF have distributed to members a Notice of Privacy Practices describing the protections of HIPAA and how these rules are applied. The Notice of Privacy Practices is on page 120 of this Handbook.

The plan or any health insurance issuer or business associate servicing the plan may only disclose member's Protected Health Information to the Plan Sponsor (Commonwealth of Pennsylvania) for purposes of plan administration consistent with the plan's governing documents and the commonwealth's agreement to abide by its obligations under this section/article.

Spousal Support Orders

A court spousal support order which directs that a retiree member provide medical coverage for his/her former spouse/domestic partner does not, and cannot require that the REHP do anything other than comply with the terms of the benefit plan, including the plan's provisions and procedures for continuation coverage under COBRA. Therefore, the retiree member or spouse/domestic partner member must duly elect, and timely pay for, COBRA coverage in accordance with the plan's COBRA requirements in order to fulfill the retiree member's obligation under the court order. Such a court order for spousal support relates only to the retiree member's obligations, as the REHP and PEBTF are not subject to the court's jurisdiction in such a legal action.

Termination or Suspension of Benefits

The REHP may terminate or suspend your benefits for any of the following reasons: (1) Failure to Repay Payments Made in Error; (2) Unauthorized Utilization; or (3) Misrepresentation or Fraud.

Failure to Repay Payments Made in Error

You are obligated to repay amounts that the REHP has paid in error to you or your dependent, or on your or your dependent's behalf. "Payment in error" includes, but is not limited to, overpayments due to an administrative error. The PEBTF has two years following the claim date to discover the overpayment and initiate a Collection Notice of Repayment. Once the PEBTF has provided notification of the overpayment to you through a Collection Notice of Repayment, you will have 30 days to repay the overpayment in full or establish a payment plan. If you fail to respond to the Collection Notice of Repayment within the established time period, you and your dependent's benefits will be suspended until the money is repaid in full. If you agree to a repayment plan and make a payment so the coverage is reinstated, and then fail to make any subsequent payment when due, you and your dependent's benefits will be suspended until the money is repaid in full. You have the right to appeal the PEBTF's demand that you reimburse amounts paid by the PEBTF in the above situation. To do so, your written appeal must be postmarked within 180 days of the date of the notice or demand to you. If you file an appeal, the suspension of your and your dependent's coverage will be stayed pending resolution of the appeal. The appeal will be considered by the commonwealth and you will be advised in writing of its decision. **The decision of the commonwealth is final.**

NOTE: Suspension of benefits in the event of a failure to repay is not a qualifying event for self-paid continuation coverage under COBRA.

Unauthorized Utilization

If you or your dependent utilizes benefits when not eligible for such benefits (i.e. loss of benefits due to divorce, etc.), you will be required to repay the PEBTF for the full amount paid. Once the PEBTF has provided notification of the overpayment to you through a

Collection Notice of Repayment, you will have 30 days to repay the overpayment in full or establish a payment plan. If you fail to respond to the Collection Notice of Repayment within the established time period, you and your dependent's benefits will be suspended until the money is repaid in full. If you agree to a repayment plan and make a payment so the coverage is reinstated, and then fail to make any subsequent payment when due, you and your dependent's benefits will be suspended until the money is repaid in full. You have the right to appeal the PEBTF's demand that you reimburse amounts paid by the PEBTF in the above situation. To do so, your written appeal must be postmarked within 180 days of the date of the notice or demand to you. If you file an appeal, the suspension of your and your dependent's coverage will be stayed pending resolution of the appeal. The appeal will be considered by the commonwealth and you will be advised in writing of its decision. **The decision of the commonwealth is final.**

NOTE: Suspension of benefits in the event of a failure to repay is not a qualifying event for self-paid continuation coverage under COBRA.

Misrepresentation or Fraud

A Member who receives benefits under the Plan as a result of the provision of false information shall be suspended from eligibility for coverage under the Plan, shall repay all amounts paid by the Fund on or after the Suspension Application Date for as long as the suspension remains in effect, and shall be liable for all costs of collection, including attorneys' fees in accordance with the following rules:

- (a) The "Suspension Application Date" shall be the date of the notice to the Member (or the Retiree Member) that benefits are being suspended, provided that, if the suspension arises from a Member's fraud or intentional misrepresentation of a material fact, the Suspension Application Date shall be the date of the initial fraud or material misrepresentation.
- (b) Where the Member who is responsible for the false information is a Retiree Member, the suspension shall apply to the Retiree Member and all of his or her dependents. The Retiree Member shall be fully responsible for the repayment of benefits and collection costs resulting from the false statement for all such individuals.
- (c) Where the Member who is responsible for the false information is the dependent of a Retiree Member, the suspension shall apply to such dependent.
- (d) If a Member's benefits have been suspended under this Section, such benefits shall remain suspended until the date that is six months after the date on which the Member pays the full amount due under this Section. If repayment is made in more than one installment, the six-month period shall begin on the date of the last installment payment, when the amount owed is fully paid. If there is no amount due, the suspension shall terminate six months after the date of the notice of suspension.
- (e) For purposes of this Section, an individual shall be regarded as the dependent of a Retiree Member if the individual is or was covered under the Plan as the Retiree Member's dependent, whether or not the individual is or ever was such a dependent.
- (f) A suspension of coverage resulting from the provision of false information will not be a qualifying event for self-pay continuation under COBRA.
- (g) For purposes of appropriate Plan administration, the Plan Administrator shall report the suspension of a Member's eligibility for coverage to the Commonwealth.

A Member may appeal his or her suspension of benefits under this Section to the PEBTF by submitting a request for such review in writing with a postmark no later than 180 days after the date of the notice of suspension. If the appeal is approved, benefits will be paid retroactively to cover any period for which benefits were improperly suspended. **The decision of the commonwealth is final.**

Time Limits

Throughout this Handbook there are provisions regarding time limits for filing claims, paying COBRA premiums and notifying the PEBTF with regard to various matters. The time limits apply to receipt of appeals or other matters within the specified time periods as set forth in this Handbook. This means that the claims payor to whom the appeal or other notification is addressed must actually receive the claim notification or appeal within the specified time. The postmark of the claim notification or appeal within the specified time is the controlling factor. These time limits must be strictly adhered to as they are strictly enforced. Do not jeopardize your rights to receive benefits by failing to observe the applicable time limits.

Veterans Administration Claims

If you receive services at a Veterans Administration (VA) hospital or outpatient facility for a non-service related injury or illness, the VA can submit a claim to the proper claims payor for the amount that would have been paid if you were not treated in a VA facility. Federal Law requires that payment go directly to the VA facility.

Some of the health plans may require that you pay for the services at the time of your visit. You will then submit a claim form to the plan. Contact your health plan for information on how the plan handles VA facility claims.

HIPAA NOTICE OF PRIVACY PRACTICES **Effective September 23, 2013**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Legal Duty of the REHP

The Retired Employees Health Program (REHP) is required by applicable federal and state laws to maintain the privacy of your personal health information, otherwise known as "Protected Health Information" ("PHI"), and to notify you in the event of a breach of unsecured PHI. The REHP is also required to give you this notice about our privacy practices, our legal duties with regard to PHI, and your rights and the rights of your dependents concerning PHI. You, and each of your covered dependents, are also sometimes referred to herein as a "Member." We must follow the privacy practices that are described in this notice once it is in effect, beginning September 23, 2013. It revises and replaces the notice of our privacy practices that was in effect prior to that date.

The REHP reserves the right to change its privacy practices and the terms of this notice at any time, in accordance with applicable law. Before we make a material change in our privacy practices, we will change this notice and provide the new notice (or notice of the changes) to you. You will receive the new notice or notice of changes if you are enrolled in our health plans at the time of the change. You may request a copy of this notice at any time. For more information about our privacy practices, or to request an additional copy of this notice, please contact the REHP by using the information listed at the end of this notice. This notice is also available at www.pebtf.org.

PHI

Protected Health Information (PHI) is a special term defined by government regulation to include any information, including genetic information, that: (i) is created or maintained by a health plan or certain other entities; (ii) relates to the past, present or future physical or mental health or condition of an individual or the provision of and/or payment for the provision of health care to an individual; and (iii) identifies the individual or provides a reasonable basis to believe that the individual could be identified. PHI may be received or maintained in any form, including oral statements. Examples of PHI are a diagnosis or procedure code combined with your name, address, Social Security number, birth date, date of service, telephone number, or fax number.

The REHP may receive PHI about you and your covered dependents from enrollment forms, which includes name, address, Social Security number, birth date, telephone number, health care provider, and other health insurance coverage. We may also receive PHI about you from other sources, such as employers, health care providers, federal and state agencies, or third-party vendors.

Except as described below, the REHP will provide access to your PHI only to you, your authorized representative, and those persons who need the information to aid the REHP in the conduct of its business ("our Business Associates") or to those you specifically authorize us in accordance with specified procedures. You have the right to revoke an Authorization,

and we describe how to do so in this notice. These formal "Authorization" rules are described in this notice.

When using or disclosing PHI, the REHP will make reasonable efforts to limit the use and disclosure of that information to the amount necessary to accomplish the intended purpose. The REHP maintains physical, technical and procedural safeguards to protect PHI and our vendors who obtain or create PHI in providing health plan services (our "Business Associates") are limited by contract and by law to using or disclosing PHI only for those purposes that it was obtained or created.

Our Uses and Disclosures of PHI

The REHP is permitted to use and to disclose PHI in order to aid in your treatment, make payment for health care services provided to you and conduct our own "health care operations." Under limited circumstances, we may be able to provide PHI for the health care operation of other providers and health plans. We may use your PHI for purposes of treatment, payment and health care operations without your Authorization. Our Business Associates will assist us in these functions, for example, by processing your claims for benefits. At times our Business Associates, including prescription drug and behavioral health vendors may handle PHI to assist us with our health care operations. Specific examples of the ways in which PHI may be used and disclosed are provided below. This list is representative only and does not include every use and disclosure in a category.

Treatment: Although the REHP does not engage in treatment activities, we may disclose your PHI to any treatment provider which asks us for this information to assist in your treatment.

Payment: The REHP may use and disclose your PHI for a variety of permitted payment activities that include, but are not limited to paying claims from doctors, hospitals and other providers for services delivered to you that are covered by your health plan.

- **Eligibility, Enrollment and Contributions:** The State Employees' Retirement System (SERS), or other State agencies, which are Business Associates of the REHP, will forward your eligibility and enrollment information to the PEBTF, also a Business Associate of the REHP, including your name, address, Social Security number and birth date. This "enrollment information" is used by the PEBTF to provide coverage for health care benefits and for eligibility determinations. The REHP may share enrollment information with the "plan sponsor" of the REHP (the Commonwealth of Pennsylvania) as permitted by law.
- **Benefits and Claims:** The REHP will use and disclose PHI to process claims and appeals and pay benefits. In doing so, we may request PHI from or disclose PHI to your health care provider or share PHI with an independent medical reviewer to obtain its clinical view as to the medical necessity or experimental nature of a medical treatment. We will send Explanation of Benefits (EOB) containing PHI to notify Members who subscribe for coverage about claim determinations. We may also use and disclose PHI for precertification and medical necessity reviews, claims management, and billing and collection activities. For example, we may provide information to the billing agent of a health care provider.
- **Coordination of Benefits, Adjudication, Subrogation:** The REHP and other health plans use and disclose PHI to coordinate the payment of benefits with other health plans (e.g., Medicare or a spouse's health insurance plan). It may be necessary for the REHP to

disclose PHI to the other plan to determine which plan should pay first and how much the secondary plan should pay. The REHP may also share information with an automobile insurance carrier, or other relevant person to assess whether another party should be liable for your medical expenses. This may be called third-party reimbursement or subrogation.

Health Care Operations: The REHP may use and disclose your PHI for health care operations. Our health care operations encompass a broad range of activities. For example, we may use and disclose PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to properly conduct our business.

- **Complaints:** The REHP may use and disclose PHI to investigate a complaint or respond to an inquiry by a Member. In order to do so, it may be necessary for us to gather information or documents, including medical records held both internally or externally by the REHP or others.
- **Customer Service:** We may provide PHI to a provider, a health care facility, or another health plan that contacts us with questions regarding your health care coverage, including questions concerning eligibility, claim status, effective dates of coverage, or other issues.
- **Audits:** We may obtain, use, and disclose PHI to audit our Business Associates, such as our managed care plans and prescription vendors, to confirm that they are paying claims accurately and otherwise performing services correctly under their contracts with us.
- **Fraud and Abuse Detection and Compliance Programs:** We may use and disclose PHI for fraud and abuse detection and in activities required by our compliance programs. We may also share this information with outside Health Oversight Agencies or other appropriate entities as required or allowed by law.
- **Health Promotion and Disease Prevention:** The REHP may use and disclose PHI for certain activities relating to improving health or reducing health care costs. For example, you may be contacted regarding participation in a disease management program or to recommend case management or certain preferred durable medical equipment vendors.
- **Legal Matters:** In the event that the REHP is evaluating compliance with certain laws, including privacy laws, or is involved in a lawsuit or other judicial or administrative proceeding, the REHP may use and disclose PHI. It may be necessary to disclose PHI to our attorneys and to others involved in the evaluations and legal proceedings. For example, we may be required to disclose PHI in response to a subpoena, warrant, or other legal process.
- **Quality Improvement:** The REHP may use or disclose PHI to help evaluate the performance of our health plan. For example, we may disclose names and addresses of our Members to a mailing house for use in mailing customer satisfaction surveys.
- **Underwriting:** The REHP may use and disclose PHI for premium rating, the creation, renewal or replacement of contracts for health insurance, or any underwriting activities; except that we may not use genetic information for underwriting purposes.

Other Uses and Disclosures of PHI

In some instances, different state and federal laws will apply to heighten the restriction on use or disclosure of your health information. In certain situations, the use or disclosure may be subject to certain prerequisites or procedures. It is not possible to include all of the examples or all of the rules applicable to the categories of permissible uses and disclosures described below.

General

You and with Your Authorization: The REHP must disclose PHI to you, as described below in the Member's Rights section of this notice. You may, subject to the REHP's policy for Authorizations, give us written Authorization to use or to disclose your PHI to anyone for any purpose. In this case, the REHP will be permitted (but not required) to use or disclose PHI, as stated in the Authorization. The REHP may prescribe an Authorization form for you to use for this purpose. You may revoke an Authorization in writing at any time; however, such revocation will not affect any uses or disclosures that were made under the Authorization while it was in effect. For additional information regarding revocation, use the contact information found at the end of this notice.

Personal Representatives: The REHP will treat your personal representative as if he/she were you for purposes of disclosing PHI. A "personal representative", for purposes of disclosure of PHI, is a parent of an unemancipated child, or a person who, as evidenced by a legal document valid under applicable law, is designated to make health care related decisions on behalf of an individual. Personal representatives include court-appointed guardians; persons appointed in "living wills" or medical directives; persons with powers of attorney that include the authority to make medical decisions; and executors/administrators of decedents' estates.

Parents and Minors: As a general rule, parents or other legal guardians have the right to access the PHI of an otherwise unemancipated minor child. However, Pennsylvania law allows a minor to obtain certain healthcare services, including contraception, pregnancy testing and treatment, prenatal care, and testing and treatment sexually transmitted diseases and HIV/AIDS without parental consent. Pennsylvania law also gives a minor the authority to control parental or other access to the PHI pertaining to such health care services. Therefore, a parent may need to obtain Authorization from the minor before the REHP will release this type of information.

Disclosures Without Your Authorization

There are certain situations in which your PHI may be used or disclosed without your authorization, as follows.

Health Oversight Activities: The REHP may share PHI as provided by law with Health Oversight Agencies regulatory authorities or their appointed designees and reporting agencies. Examples of such "Health Oversight Agencies" include, but are not limited to, Centers for Medicare and Medicaid Services, the Pennsylvania Department of Health, Insurance Department, Attorney General, and Auditor General.

Business Associates: The REHP works with many entities that perform a wide variety of services on its behalf. For example, we work with auditors, attorneys, actuaries, consultants, and other health care plans who act as third-party administrators for the REHP. We will ensure that appropriate agreements are in place to govern the permitted and

required uses and disclosures of Member information by our Business Associates, to require our Business Associates' compliance with applicable privacy laws, and to require our Business Associates to apply reasonable safeguards to the PHI they obtain or create in the services that they provide with regard to the REHP.

Individuals Involved in Your Care: We generally will not disclose PHI to others without your written Authorization. However, under certain circumstances, the REHP may disclose PHI to such persons. For example, if you appear at the offices of the PEBTF with your spouse/domestic partner/family Member and ask for PHI, you may be asked if your PHI may be disclosed in front of your spouse/domestic partner/family Member or your Authorization may be inferred because your spouse/domestic partner/family Member is present.

We may also disclose PHI to your family Members, close friends or others in cases of a medical emergency, when you are unable to provide Authorization. In such cases, the REHP will disclose PHI to another person if we determine, using our professional judgment, that the disclosure would be in your best interest. In such cases, we will disclose only the PHI that is relevant to that person's involvement with your health care.

Disaster Relief: In the event of a disaster, the REHP may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts, such as the American Red Cross.

Plan Sponsor: The REHP may disclose eligibility, enrollment, and limited disenrollment information to our plan sponsors to permit them to perform their plan administrative functions on behalf of the REHP. We may provide our plan sponsor with information of your enrollment or disenrollment for coverage. We may also disclose summary health information about you and the participants in your group health plan to our plan sponsor for the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan and/or to decide whether to modify, amend or terminate your group health plan. This summary health information may include claims history, claims expenses, or types of claims experienced by the participants in the REHP. The summary information will be stripped of demographic information (e.g., name and address) other than your zip code information. In order to obtain any of the above information, the plan sponsor will be required to certify to us that the plan has been amended to provide that the confidentiality of the information will be protected and that the information will not be used in any employment related decisions. No other information will be shared with the plan sponsor without an Authorization executed according to the REHP's Authorization policy.

Public Health and Communicable Disease Reporting: The REHP may disclose your PHI to a public health authority that is permitted by law to collect or receive the information. Such disclosure may be made in order to prevent or control disease, injury or disability, report child abuse or neglect, notify a person who may have been exposed to a disease or may be at risk for contracting a disease or condition or notifying the appropriate government authority if we believe a Member has been the victim of abuse, neglect or domestic violence. The REHP may use or disclose PHI to assist in certain other public health activities as permitted or required by law.

Research, Death, Organ Donation: The REHP may use or disclose your PHI for research purposes, in limited circumstances and with certain safeguards. The PHI of a deceased person may be disclosed to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Required by Law: The REHP may use or disclose your PHI when we are required to do so by law. For example, we are required by federal law to disclose PHI to the U.S. Department of Health and Human Services if it asks to see it for purposes of determining whether we are in compliance with federal privacy laws. We may also disclose your PHI when authorized by Workers' Compensation or similar laws.

Law Enforcement and for Public Safety: Under certain circumstances, the REHP may disclose your PHI for law enforcement purposes. Examples of such situations include responding to court orders, warrants, or grand jury subpoenas; providing limited PHI in response to requests by law enforcement officials for identification and/or location of a suspect, witness, or certain other individuals; responding to inquiries by law enforcement relating to victims of crime; and providing information to law enforcement with respect to crimes occurring on the PEBTF's premises. In addition, under some circumstances, the REHP may disclose your PHI in order to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Examples include providing information to law enforcement authorities in their effort to apprehend a suspect or fugitive or advising an individual about threats made against them. Finally, the REHP may disclose your PHI if you are an inmate or a person in lawful custody and a request for your PHI is made by an appropriate law enforcement official or correctional institution.

Military, Veterans Activities and National Security: Under certain circumstances, the REHP may disclose the PHI of armed forces personnel to military or veterans authorities. The REHP may also disclose your PHI to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities.

Disclosures Requiring Your Authorization

Except as otherwise described in this notice, we may not use or disclose your protected health information without a valid authorization. When we receive a valid authorization, our disclosures must be consistent with that authorization. Your authorization is required for release of psychotherapy notes (with only a few narrow exceptions), for release for marketing purposes, and for the sale of your information.

Member Rights

As a Member of the REHP, you have the following rights regarding your PHI:

- **Right to Inspect and Copy:** With limited exceptions, you have the right to inspect and/or obtain a copy of your PHI that the REHP maintains in a designated record set. A "designated record set" consists of all records used by the REHP to make health plan decisions about you, including documentation relating to your enrollment, payment, claims adjudication, and case or medical management (e.g., disease management). You may request that the REHP provide copies of your PHI to you in paper or electronic format. If we can readily produce the PHI in that format, we will do so. You may also designate another person to receive this PHI and request that we send the PHI to that person directly by properly completing and submitting an Authorization to us. You may obtain an Authorization form to make these requests by using the contact information found at the end of this notice.

If the Designated Record Set is located on-site, the REHP will act upon your written request within 30 days after receipt of the request. If the PHI is not maintained by, or accessible to, the REHP on-site then it will respond to you no later than 60 days after receipt of the request. If these time frames cannot be met, the REHP is entitled to a 30

day extension. We will provide you with a notice of the reasons for the delay and the length of the extension. The REHP may charge you a reasonable cost-based fee to process and fulfill your request. If you prefer, you may request that the REHP prepare a summary or an explanation of your PHI; the REHP may also charge a fee to process and fulfill this request. Contact the REHP using the information listed at the end of this notice for a full explanation of its fee structure. If your request for access is denied, the REHP will provide a written explanation of the denial and your rights regarding the denial.

To obtain information about your treatment, you may wish to contact your treating physician, facility, or other provider that creates and/or maintains the records.

- **Right to Amend:** You have the right to request the REHP amend the PHI that we have created and that is maintained in the Designated Record Set. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information found at the end of this notice.

The REHP cannot amend demographic information, treatment records or any other information created by others. If you would like to amend any of this information, please contact the State Employees' Retirement System (SERS) or, to amend your treatment records, you must contact the treating physician, facility or other provider that created these records.

The REHP will act on a request for an amendment within 60 days of receipt, or provide a written statement of the reason why it cannot do so and the date by which it will complete action on the request. If we accept the amendment, we will advise you and make reasonable efforts to inform others who have the relevant record, including people you authorize, of the amendment and to include the changes in any future disclosures of that information.

The REHP may deny your request if: 1) the REHP did not create the information you want amended; 2) the information is not part of the designated record set maintained by the REHP; 3) you do not have access rights to the information; or 4) the REHP believes the information is accurate and complete. If the REHP denies your request, you will be provided a written explanation for the denial and your rights regarding the denial.

- **Right to an Accounting of Disclosures:** You have the right to receive an accounting of certain specific instances in which the REHP or its Business Associates have disclosed your PHI. The accounting will review disclosures made over the past six years. The REHP will provide you with the date of a disclosure, the name of the person or entity to whom your PHI was disclosed (unless this information is PHI of another Member), a description of the information disclosed, the reason for the disclosure, and certain other information. Certain disclosures, including the most routine disclosures (e.g., those made for treatment, payment or health care operations or made in accordance with an Authorization) are not subject to this requirement and will not appear in the accounting.

Your request for an accounting must be made in writing. You may obtain a form to request an accounting by using the contact information found at the end of this notice. The REHP will act on your request within 30 days of receipt, or you will be provided with a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request an accounting more than once in a 12 month period, the REHP may charge you a reasonable, cost-based fee for responding to these additional requests. You will have the opportunity, in writing, to withdraw or modify your request for any subsequent accounting in order to avoid or reduce the fee. You may contact us using the information listed at the end of this notice for a full explanation of the REHP's fee structure.

- **Right to Request Restrictions:** You have the right to request that the REHP place additional restrictions on the use or disclosure of your PHI for treatment, payment, health care operations purposes, and for disclosures made to persons involved in your care. The REHP is not required to agree (unless the disclosure is about payment or operations, is not required, and has to do with a service that was paid for by you or another party), and for administrative and other reasons, we generally will not agree to these additional restrictions. However, if the REHP does agree, we will abide by our agreement (except in an emergency). If the REHP does agree to a restriction, our agreement will always be in writing and signed by the REHP's Privacy Officer. If we agree to a restriction, we reserve the right to terminate that agreement by providing you with written notice of that termination.

Your request for restrictions must be in writing. You may obtain a form to request such restrictions, or additional information about your rights to request restrictions, by using the contact information found at the end of this notice.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you in confidence about your PHI by using "alternative means" or an "alternative location" if the disclosure of all or part of that information to another person could endanger you. We will accommodate such a request where you clearly advise us in your request that the usual means of communication could endanger you and if your request for an alternative is reasonable. Your request must, among other things, continue to permit the REHP to collect premiums and pay claims under the health plan.

To request confidential communication changes, you must make your request in writing, and you must specify the alternative means or location for communication, and you must clearly state that the information could endanger you if it is not communicated in confidence as you request. To obtain a form to request confidential communications, use the contact information found at the end of this notice.

Right to Receive a Paper Copy of the Notice

If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact the REHP using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about the REHP privacy practices or have questions or concerns, please contact the REHP using the information listed at the end of this notice.

If you are concerned that the REHP may have violated your privacy rights, or you disagree with a decision the REHP made about access to your PHI or in response to a request you made to amend or restrict the use of disclosure of your information or to have the REHP communicate with you in confidence by alternative means or at an alternative location, you

must submit your complaint in writing. To obtain a form for submitting your complaint, use the contact information found at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services (HHS). The REHP will provide you with the address to file your complaint with the HHS upon request.

The REHP supports your right to protect the privacy of your PHI. The Commonwealth will not retaliate in any way if you choose to file a complaint with it or with the U.S. Department of Health and Human Services.

Contact Office: Bureau of Employee Benefits Telephone: (717) 787-9872

Address: PA Office of Administration
613 North Street
Room 402, Finance Building
Harrisburg, PA 17120

Fax: (717) 787-7763

E-mail: ra-benhelp@pa.gov

Glossary of Terms

Acute: Rapid onset of severe symptoms and a short course; not chronic

Chronic: Slow onset and lasting for a long period of time.

Claims Payor: The PEBTF or other organization that adjudicates claims under the authority of the REHP, including but not limited to, Blue Cross, Blue Shield, various PPO, or HMO network providers or other third party administrators selected by the Fund.

When the REHP selects a PPO, HMO, prescription benefit manager or other third party administrator as the claims payor for an REHP plan option, that claims payor has the discretion and authority to render decisions on claims for benefits under the plan, to apply exclusions under the plan (for example, to determine whether a service is experimental or investigative), to determine whether a service is medically necessary and to determine the applicable plan allowance. The REHP or other claims payor has the authority and discretion to interpret and construe the terms of the plan and apply it to your factual situation.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 30%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.

Copayment: Pre-established payment that must be made by you under the particular plan (e.g., for a doctor's office visit, for emergency care or for a prescription).

Covered Service: Service or charge that is allowed under the plan, which is medically necessary and which is rendered by an eligible provider or supplier.

Curative Treatment: Having healing or remedial properties.

Deductible: Amount you must pay each plan year before the plan pays benefits.

Dependent: The spouse/domestic partner or child of a retiree member who meets the eligibility requirements of the plan and has been enrolled by the retiree member as an eligible dependent. (See Eligibility section)

Diagnostic service: Procedures ordered by a physician or professional provider because of specific symptoms to determine a definite condition or disease.

Domiciliary Care: Home care providing mainly custodial and personal care for people who do not require medical or nursing supervision but mainly need assistance with activities of daily living because of a physical or mental disability.

Eligible member: An eligible member means a member enrolled in the REHP, whether as a retiree member, a COBRA qualified member ("COBRA member"), a Survivor Spouse member, or the enrolled eligible dependent of a retiree member or COBRA member. The term, "member" for purposes of this Handbook, means and is limited to an eligible member. If you were previously enrolled for coverage but are not an eligible member, refer to the Handbook in effect when your coverage ended.

Experimental or Investigative: Services or supplies which the claims payor for the health plan option you have selected determines are:

- a. Not of proven benefit for the particular diagnosis or treatment of a particular condition;
- or

- b. Not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
- c. Provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

HMO (Health Maintenance Organization): A health care option that uses a network of health care providers, including physicians, hospitals, laboratories, rehabilitation and nursing home facilities. HMO network providers have contracts with "health management companies" which bind them to certain rules, including fees. HMOs' rules also bind enrollees to obtaining care only by following specified procedures.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care: Equipment and services to the member in the home for the purpose of restoring and maintaining maximum levels of function and health of the member.

In-network: Care received from your Primary Care Physician or from a referred network specialist (PPO, HMO and Mental Health and Substance Abuse Program).

Maximum: The greatest quantity or amount payable to or for a member or available to a member, under the covered services section of the applicable plan option. The maximum may be expressed in dollars, number of days or number of services, for a specified period of time.

Medically Necessary (or Medical Necessity): Services or supplies that are provided by a hospital or other facility provider, or by a physician or other professional provider that the claims payor for the health plan option you have selected determines are:

- a. Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury; and
- b. Provided for the diagnosis, or the direct care and treatment of the member's condition, illness, disease, or injury; and
- c. In accordance with standards of good medical practice; and
- d. Not primarily for the convenience of a member or the member's provider; and
- e. The most appropriate supply or level of service that can safely be provided to the member. When applied to hospitalization, this means that the member requires acute care as a bed patient due to the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care as an outpatient.

Medicare: Programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended. Medicare includes: Hospital Insurance (Part A) and Medical Insurance (Part B), Medicare Advantage (Part C) and Prescription Drug (Part D).

Medicare Open Access PPO: A Medicare Advantage Plan offered by a private insurance company. Medicare pays a set amount of money every month to the Medicare Open Access PPO to arrange for health care coverage for Medicare members enrolled in the plan.

Member: Enrolled person eligible for benefits under the REHP, which includes eligible retirees, their eligible dependents, eligible COBRA beneficiaries and eligible surviving spouses/domestic partners (see also Eligible Member).

Mental Health and Substance Abuse Program: This program provides independent, stand-alone, mental health and substance abuse rehabilitation treatment services, whether inpatient or outpatient through a specialized network of professional providers and treatment facilities. Inpatient detoxification services will be provided through your medical plan option as appropriate.

Network providers: Medical providers, such as doctors and hospitals, who have a contractual agreement with PPO, HMO plans, or the Mental Health and Substance Abuse Plan to provide medical services or mental health services to enrolled members.

New Child: A new child means, with respect to any eligible retiree or dependent of an eligible retiree, a child who is newly born to, newly adopted by, or newly placed for adoption with the eligible retiree or dependent, as applicable.

Open Enrollment: Period of time specified by the REHP during which members may, in accordance with the established eligibility rules, change the plan option in which they are enrolled.

Out-of-Network: Care provided by physicians or other medical professionals who have not contracted to provide services within the parameters established by a health or dental management company (PPO, HMO or Mental Health and Substance Abuse Plan).

Out-of-pocket maximum: The amount of eligible expenses you pay before the plan begins to pay at 100%.

Palliative: Relieves or alleviates without curing.

Part D: Medicare prescription drug coverage which is run by a Medicare approved private insurance company.

Plan allowance: Certain claims payors determine the maximum covered expenses for a covered service by means of the plan allowance, rather than by determining the UCR charge. The plan allowance means the fee determined and payable by the claims payor for covered services as follows:

- a. For preferred providers, the plan allowance is the lesser of the provider's billed amount or the amount reflected in the Fee Schedule determined by the claims payor. The Fee Schedule is the document(s) that outlines predetermined fee maximums that Participating and non-participating providers will be paid by the claims payor, as amended from time to time.
- b. For participating facility providers, the plan allowance is the negotiated amount agreed to by the provider and the claims payor. For non-participating facility providers, the plan allowance is the amount charged by the facility provider to all its patients, but not in excess of the Fee Schedule or other maximum payment amount, if any, established by the claims payor with respect to Non-participating facility providers.

PPO (Preferred Provider Organization): Offers both in-network and out-of-network benefits. Members do not have to choose a Primary Care Physician (PCP) to direct in-network care. Medically necessary care received by a PPO network provider or facility is subject to a copayment. Out-of-network care is subject to an annual deductible and coinsurance.

Prescription benefit manager: The claims payor for the Prescription Drug Plan.

Primary Care Physician (PCP): The physician you choose to coordinate your care. PCP's are family practice doctors, general practitioners, internists or pediatricians.

Provider: Hospital facility other provider, physician or professional other provider licensed, where required, to render covered services.

Qualifying life event: A qualifying life event means, subject to any restriction under applicable law or any plan option, any of the following events:

- a. An eligible retiree gains a new dependent through birth, adoption or marriage.
- b. An eligible retiree loses a dependent through divorce, termination of a domestic partnership, or death.
- c. A retiree's dependent ceases to be eligible for coverage under the terms of the plan or a plan option.
- d. An Eligible Person experiences a termination or commencement of employment, strike or lockout, commencement of or a return from a leave of absence, change in worksite, or other change in employment status that causes the individual to become or cease to be eligible for coverage under a health plan maintained by his or her employer.
- e. An Eligible Person changes his/her residence and, as a result, becomes ineligible for a plan option in which he/she is enrolled or eligible for a new plan or plan option.
- f. The cost of coverage under a plan option to an eligible retiree significantly changes.
- g. An Eligible Person is enrolled in a plan option that ceases to be available to the Eligible Person because the plan option ceases to be offered under the plan or the plan option's service area is reduced or there is a substantial reduction in providers in the plan option's network.
- h. A new plan option is added.
- i. An Eligible Person gains or loses group health coverage under another plan because of:
 - a. A change of election under another employer's plan that is made either during an annual enrollment period for a period of coverage that differs from the Plan Year or outside of an annual enrollment period pursuant to provisions under that employer's plan for reasons equivalent to a qualifying life event;
 - b. A loss of coverage under a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Services, or a tribal organization; a State health benefits risk pool, a foreign government group health plan or similar program for group health coverage sponsored by a governmental or educational institution.
- j. The plan receives a qualified medical child support order or other applicable judgment, decree or order resulting from divorce, legal separation, annulment, or change in legal custody that requires coverage of an eligible retiree's child under the plan or a plan option or a child coverage order that requires a spouse/domestic partner, former spouse/domestic partner, or other individual to provide accident or health coverage to the eligible retiree's child (and the coverage is actually provided).
- k. An Eligible Person becomes entitled to, or is entitled to and loses eligibility for, coverage under Part A or Part B of Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, other than coverage solely related to the distribution of pediatric vaccines under section 1928 of such Act.
- l. An Eligible Person incurs a special enrollment event.

- m. A member's receipt of an order from a court or other authority directing the member to disenroll the member and/or dependent.
- n. Spouse/domestic partner or other eligible member is enrolled in a high-deductible plan with Health Savings Account (HSA) coverage through his/her employer.
Spouse/domestic partner or other eligible member may be removed from REHP coverage to avoid any tax penalties.

Respite Care: Services that provide a break for the caregiver of the chronically ill.

Skilled Nursing Facility (SNF): Medicare-certified institution which is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for rehabilitation of injured, disabled or sick persons; and is duly licensed and regularly provides 24-hour skilled nursing care by and under the direction of licensed, qualified registered nurses (RN's), and which also provides therapeutic services by licensed, qualified therapists, acting within the scope of their licenses.

Special Enrollment Event: Special enrollment event means a special enrollment event within the meaning of HIPAA, with respect to which the plan is required to offer eligible retirees and their dependents an opportunity for coverage under plan options. A special enrollment event is any of the following events:

- a. The marriage of an Eligible retiree
- b. The birth of a child of, adoption of a child by or placement for adoption of a child with an eligible retiree
- c. An eligible retiree's loss of eligibility coverage under another employer's plan, other than for a failure to pay premiums or other cause (for which purpose, for continuation of health coverage under COBRA, only the exhaustion of the maximum continuation coverage period shall be regarded as a special enrollment event)
- d. Another employer's termination of all employer contributions toward the cost of coverage (other than COBRA coverage)
- e. In the case of an eligible retiree who is not enrolled for coverage under the plan or an eligible member's dependent either: (i) a loss of eligibility for coverage in a Medicaid plan under Title XIX of the Social Security Act or a state child health care plan under title XXI of the Social Security Act; or (ii) a commencement of eligibility for assistance with coverage under the plan provided by a Medicaid plan under title XIX of the Social Security Act or a state child health care plan under title XXI of the Social Security Act.

Treatment Plan: Projected series and sequence of treatment procedures based on an individualized evaluation of what is needed to restore or improve the health and function of a patient.

UCR (Usual, Customary, and Reasonable) Charge: The maximum covered expense for a covered service in the service area. Expenses in excess of the UCR charge are the sole responsibility of the member when non-participating providers are used. The UCR charge is determined by the claims payor under the particular plan option you have selected (PPO, HMO, Mental Health and Substance Abuse Program) in accordance with the following factors:

- The usual fee which an individual provider most frequently charges to the majority of patients for the procedure performed
- The customary fee determined by the claims payor based on charges made by providers of similar training and experience in a given geographic area for the procedure performed
- The reasonable fee (which differs from the usual or customary charge) determined by the claims payor by considering unusual clinical circumstances; the degree of professional involvement or the actual cost of equipment and facilities involved in providing the service

The determination of the UCR charge made by the claims payor will be accepted by the REHP for purposes of determining the maximum amount of expense eligible for coverage under the plan. Certain claims payors use the "plan allowance" in place of the UCR Allowance. Any reference to "UCR" or the "UCR Allowance" shall be deemed to refer to the "plan allowance" for those plan options which are administered by a claims payor that uses the plan allowance.

NOTE: Certain claims payors use the "plan allowance" instead of the UCR charge for determining the maximum covered expense. Any reference hereunder to the "UCR" or the "UCR charge" shall be deemed to refer to the plan allowance for those plan options administered by a claims payor that uses the plan allowance.

Who Do I Contact?

	PEBTF 800-522-7279	SERS 800-633-5461	Health Plan (Contact the PEBTF for plan telephone numbers or refer to your plan ID card)
If I have questions about my health benefits	✓		
If I have a question about my retirement annuity		✓	
If I have to report an address change or phone number change	✓	✓	
To add or remove a dependent from coverage		✓	
To report a divorce or termination of domestic partnership (spouse/domestic partner must be removed from REHP benefits)		✓	
To report a retiree's death		✓	
To apply for disabled dependent coverage	✓		
To voluntarily "opt out" of medical and/or prescription drug benefits		✓	
To report eligibility for Medicare – Medicare Part A and Medicare Part B	✓		
To order a new medical ID card			✓
To appeal a denied claim or service			✓
To request an exception to the Medicare plan enrollment requirements	✓		

IMPORTANT TELEPHONE NUMBERS

PEBTF 717-561-4750 (Local)
www.pebtf.org 800-522-7279 (Toll Free)

Non-Medicare Eligible Options

PPO Option

Choice PPO 800-991-9222
Basic PPO 888-301-9273

HMO Option (REHP Custom HMO)

West - Aetna 800-991-9222
Central - Aetna 800-991-9222
Southeast - Aetna 800-991-9222
Northeast - Geisinger 800-504-0443

Mental Health and Substance Abuse Program

Optum 800-924-0105
State Employee Assistance Program 800-692-7459

Durable Medical Equipment (DME), Prosthetics, Orthotics and Medical Supplies

DMEnson Benefit Management 888-732-6161

Medicare Eligible Options

Medicare Open Access

Aetna Medicare Open Access PPO 888-272-5651

Non-Medicare & Medicare Eligible Members

Prescription Drug Benefits

CVS Caremark (non-Medicare) 888-321-3261
SilverScript (Medicare) 866-329-2088

For health plan website addresses, log on to the PEBTF website, www.pebtf.org. You will find the plan's website addresses listed under the Links section.